

Nicholls, Nicole (2014). Engaging Men, An Exploration of the Help-Seeking Experiences of Male Survivors of Childhood Sexual Abuse. (Unpublished Doctoral thesis, City University London)



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**Engaging Men,  
An Exploration of the Help-Seeking  
Experiences of Male Survivors of Childhood  
Sexual Abuse**

**By Nicole Nicholls**

**Thesis submitted to fulfil the requirements of the  
Professional Doctorate in Counselling Psychology**

**City University**

**Department of Psychology**

**Submitted February 2014**

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## **Acknowledgements**

Thank you to my supervisor, Dr Jacqui Farrants, for her interest and support through the process of the Doctoral research. Her insight, enthusiasm and encouragement have been inspiring and very much appreciated.

I would like to acknowledge the client, whose experience touched me and inspired me to explore this topic. I am also indebted to the seven participants who were willing to take part in this research, and I am privileged that they chose to share their experiences with me.

Lastly, I would like to thank my family: my parents and grandparents, and my partner and children, who have motivated me and supported me throughout.



## **Declaration**

I grant powers of discretion to the University Librarian to allow this Doctorate Portfolio to be copied in whole or in part without further reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

## Key to Abbreviations

The following table expands abbreviations used throughout this portfolio.

Abbreviation	Meaning
BPS	British Psychological Society
BPSS	British Psychological Society Scotland Survivors of Childhood Sexual Abuse Working Party
CBT	Cognitive Behaviour Therapy
CP	Counselling Psychologist
CSA	Childhood Sexual Abuse
DA	Discourse Analysis
GP	General Practitioner
IAPT	Improving Access to Psychological Therapies
IPA	Interpretative Phenomenological Analysis
NAPAC	National Institute of People Abused in Childhood
NICE	National Institute of Clinical Excellence
NSPCC	National Society for the Prevention of Cruelty to Children
PTSD	Post-Traumatic Stress Disorder

## **Preface**

### **Outline of Preface**

The preface introduces this Doctorate Portfolio, which consists of three pieces of work related to the topic of male childhood sexual abuse (CSA) and to the practice of Counselling Psychology. Each piece of work will be introduced below. This is followed by a section which describes the linking themes that bring the separate pieces of work together.

### **Outline of Portfolio**

The first piece of work (Part A: The Research) presents a qualitative research study, the aim of which was to explore the in-depth lived experiences of help-seeking in seven adult male survivors of CSA to address the lack of current literature with this population and on this topic area. Semi-structured interviews enabled participants to share their experiences, providing some insight into male survivors' experiences of help-seeking. Data were analysed using Interpretative Phenomenological Analysis, a qualitative approach facilitating in-depth analysis of a phenomena (Smith, Flowers & Larkin, 2009). Using this method, the four master themes which emerged illuminate the experiences of men as they navigated through their unique journeys of seeking help. The themes and discussion demonstrate the complexities and issues that arose for the participants, and the findings are discussed with reference to both theoretical insights and the existing body of literature on male CSA and help-seeking. Implications for the practice of Counselling Psychology are identified and discussed.

The second part of this portfolio (Part B) provides a detailed reflection of a case study completed during the first year of the Doctoral training. The work demonstrates my first experience of therapy with a male survivor of CSA and his experience of disclosure in the context of therapy. The case was chosen to illustrate my learning and development, as well as my ability to reflect on clinical practice to enhance future practice. The anxieties of being a Trainee continue to resurface when presented with new ventures or challenges. My first experience in working with a male survivor presented one such challenge, mainly due to my incessant need to want to know 'everything' and my naivety that I could 'help' everyone. This case study is followed by a critique and reflections on this work, considering the advancement of my learning to date.

The third component (Part C) presents a condensed version of the research prepared for submission to an academic journal. The focus of the paper is on help-seeking and the importance of disclosure in mediating this process. The format for the paper is based on the guidelines for submission from the *Journal of Child Sexual Abuse*, a primary source of peer-reviewed published research concerning the topic of sexual abuse. As such, this was considered an appropriate target for this paper. Appendix I includes the author guidelines for the journal.

### **Linking Themes – Men, Childhood Sexual Abuse and Help-Seeking**

An important theme embedded amongst all three pieces of work is the need to acknowledge and engage men as survivors of childhood sexual abuse. Existing literature has documented the need for more research in this area to further understanding of the needs of men and issues that may present for them as adults (Mendel, 1995; Dube, Anda, Whitfield, Brown, Felitti, Dong & Giles, 2005). In beginning my Doctoral training, my work in a substance misuse service opened my eyes to the topic of sexual abuse. I worked with male and female clients, one-to-one and in groups, who had suffered significantly due to experiencing childhood trauma, including CSA, and who used substances to cope with their trauma. Observing and learning of the difficulties they experienced in and out of the therapy room led to my interest in learning more and my desire to work with this client group. I found a variety of services where I could sign-post and refer my female clients on to for both practical and emotional support; however, for men it was a different story. The men's group running in the area had recently closed due to lack of funding, and other options for engaging in counselling and therapy were limited or required a financial commitment. A number of my clients had experienced difficulties for many years, were unemployed and did not have the option of funding private therapy. I became interested in the psychological approaches used in therapy with survivors of CSA and began volunteering in an organisation which supports survivors of abuse in childhood. I worked with John (my client discussed in Part B) for over a year. I subsequently decided to carry out my research with male survivors of CSA to understand their experiences of help-seeking. Therefore, both the professional practice, which described a disclosure in therapy, and the research study, exploring men's experiences of help-seeking, are linked by the theme I have entitled 'Engaging Men', highlighting the need to recognise men as survivors of CSA. The phenomenological stance of the research complements the use of the person-centred approach used in the original client study.

The practice of Counselling Psychology in the UK takes place in an environment which advocates the use of evidence-based practice, and takes in to account the national guidelines produced by NICE regarding therapeutic approaches for a number of mental health disorders, including depression (NICE: 2009) and Post-Traumatic Stress Disorder (PTSD, NICE: 2005). Such guidance does not exist for survivors of sexual abuse, who often present across all mental health disorders. Silverman, Reinherz and Giaconia (1996) for example, found that eighty per cent of CSA survivors fit the diagnostic criteria of at least one psychiatric disorder. This is supported by Maniglio (2009), Warne and McAndrew (2005, p. 679), who also report that CSA is contributing factor for medical, psychological and behavioural disorders for both sexes. Counselling Psychologists will no doubt come in to contact with male survivors during their careers, thus being able to respond to their needs and facilitate help-seeking may potentially ameliorate further distress. The sexual abuse of men has been forced in to the limelight with the recent allegations involving the sexual abuse of boys at various religious establishments, and the trials of celebrities involved in childhood sexual abuse cases. Due to this enhanced media attention, society is faced with the extent and impact CSA can have, highlighting the silence that has surrounded this taboo subject for many years.

In presenting this portfolio, I share not only my participants' journeys of help-seeking, but my own journey of developing as a Counselling Psychologist. Over the three years of training, and in completing this Doctoral Portfolio, I have been able to reflect on and re-evaluate my initial expectations of myself, wanting to heal everyone and make everyone's problems better. I have learnt that the role of a Counselling Psychologist is to facilitate an individual's own resources for growth and change. Therefore, in presenting my work, I hope to illustrate my journey and the idea of being unconsciously incompetent to consciously competent (Driscoll, 2000). My aim for the future is to continue developing my skills and embracing new experiences, and in doing so, hopefully becoming 'unconsciously competent' but always reflecting on myself and my work.

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## **Part A: The Research**

### **‘Engaging Men’**

#### **Experiences of Help-Seeking after Childhood Sexual Abuse: An Interpretative Phenomenological Analysis**

**By Nicole Nicholls**

**City University**

**Supervised by Dr Jacqui Farrants**

## **Abstract**

Counselling Psychologists working in a variety of settings are likely to encounter male clients who have significant histories of childhood trauma, including childhood sexual abuse (CSA). The existing literature on the topic of CSA is largely quantitative, and whilst there is qualitative research that explores adult female experiences of CSA, research concerning men's perspectives is limited. This qualitative phenomenological study examined the experiences of help-seeking in male survivors of CSA with the aim of advancing understanding of this phenomenon to inform and enhance clinical practice.

Seven participants who identified themselves as survivors of CSA took part in semi-structured interviews, which were analysed using Interpretative Phenomenological Analysis. Analysis of the data revealed four master themes: 'Disclosure', 'Searching', 'The Help-Seeking Journey' and 'Making Sense and Moving Forwards'. It is argued that this research offers an embodied account of male help-seeking experiences following CSA, which is currently lacking from the current literature. The findings have implications for clinical practice, service provision, policy development and professional training in the field. It is also hoped that they will inform the work of Counselling Psychologists who enter into therapy with men who have experienced CSA.



## Chapter 1: Introduction

*'For growth to occur, men's pain cannot remain hidden or misunderstood'*

(Brooks, 2001, p. 294)

Several decades ago, Childhood Sexual Abuse (CSA) was rarely mentioned and little was known about the long-term developmental or psychological consequences for survivors (Mash & Wolf, 2002). The empirical literature on CSA has since developed, with a concomitant increase in the number of studies published (Bolen, 2001). Advances in this area have led to an array of research demonstrating that the effects of CSA can extend into adulthood, impacting on physical, psychological and social functioning and contributing to adult psychopathology (Briere & Elliott, 2003; Briere & Runtz, 1990; Calder, McVean & Yang, 2010; Leeb, Lewis & Zolotor, 2011; O'Leary, Coohey & Easton, 2010; Maniglio, 2009). Existing literature on the topic of CSA is largely quantitative, and whilst there is qualitative research that explores adult female experiences of CSA, research concerning men's perspectives is limited. This chapter provides an introduction to the research topic, followed by a review of the existing literature concerning adult male survivors of CSA. The term 'survivor' is used throughout this research to refer to adults who define themselves as having experienced childhood sexual abuse.

### Defining Childhood Sexual Abuse

Due to variations in definitions of CSA in existing literature, it was considered necessary to provide a definition for the reader. For the purpose of this research, the definition provided by the National Society for the Prevention of Cruelty to Children (NSPCC) will be referred to:

*Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet). Sexual abuse is not solely perpetrated by adult males.*

*Women can also commit acts of sexual abuse, as can other children (Radford, Corral & Bradley et al., 2011).*

As illustrated, an array of sexual acts are covered by the term 'sexual abuse'. This diversity leads to a range of outcomes amongst survivors of CSA and contributes to the methodological criticisms of existing research. In addition, the age and gender of the child, the age and gender of the perpetrator, the nature of the relationship between the child and perpetrator, and the number, frequency and duration of the abuse experiences appear to influence the impact of CSA. The Sexual Offences Act 2003 states that:

*A person aged 18 or over (A) commits an offence if a) he intentionally touches another person (B), b) the touching is sexual and c) either (i) B is under 16 and A does not reasonably believe that B is 16 or (ii) B is under 13 (Sexual Offences Act, 2003).*

For the current study, the researcher has attempted to incorporate as many different aspects of sexual abuse into her understanding of this phenomenon as possible. As such, any action of a sexual nature, when an individual who is older than the child uses that child (either forcibly or non-forcibly) for their own sexual gratification, is considered to be a form of sexual abuse.

### **The Scope of the Problem**

Society has taken its time in recognising and responding to CSA; however, recent media attention following claims of clergy abuse and allegations in them media against various celebrities has forced this topic into the limelight. CSA is largely hidden and unreported; therefore, it is impossible to gain an accurate picture of those affected. Prevalence is extremely difficult, if not impossible, to establish (Butler-Sloss, 1988; Kempe & Kempe, 1984; Summit & Kryso, 1978). Nevertheless, studies of population-representative samples provide useful data for consideration.

In 1994, Laumann, Gagnon, Micheal and Micheals carried out a comprehensive representative survey of sexual practices in the general adult population of the United States. From a survey of over 3,400 adults, 12 % of men and 17 % of women reported that they had been sexually touched in childhood. Of those who reported contact sexual abuse before puberty, 74% of women and 78% of men did not tell anyone during their childhood. Research

investigating the prevalence, correlates and consequences of sexual coercion in Australian adults revealed that amongst a representative sample of 10,173 men and 9,134 women aged 16–59 years, 2.8% of men and 10.3% of women had been sexually coerced when aged 16 or younger (de Visser, Smith, Rissel, Richters & Grulich, 2003). Similar findings are illustrated by Choi, Binson, Adelson and Catania (1998), who provided an estimate of the national prevalence of sexual harassment and sexual coercion. Data came from a 1992 telephone survey of a random probability sample of 2,030 U.S. adults aged 18–49 years. 16% of men and 33% of women reported having been sexually harassed, and 4% of men and 16% of women reported having been sexually coerced. A meta-analysis of 65 articles from 22 countries investigating the prevalence of CSA amongst adults reported that 7.9% of men and 19.7% of women had experienced sexual abuse prior to the age of 18 (Pereda, Guilera, Forns & Gómez-Benito, 2009). UK data from a study by Cawson, Wattam, Brooker & Kelly (2000) studying 2,869 young adults aged 18–24 reported that 11% of males had experienced sexual abuse in childhood. More recently, child abuse and neglect in the UK today (Radford, Corral & Bradley, 2011), a major piece of NSPCC research, interviewed 1,761 young adults aged 18–24, 2,275 children aged 11–17 and 2,160 parents of children aged under 11 and reported that that one in 20 children had experienced sexual abuse, and more than one in three children (34%) who experienced sexual abuse by an adult did not tell anyone else about it at the time. The study also cites that 18,915 sexual crimes against children under 16 were recorded in England and Wales in 2012/13.

Statistics on the prevalence of CSA are derived primarily from retrospective accounts by adults from both clinical and non-clinical samples. It is not surprising that prevalence figures vary widely as a result of the selection and response rate, the definition used and the method (e.g. self-report versus structured interview) by which an abuse history is obtained. Furthermore, since the change in 1994 to the Sexual Offences Act 1976, which was amended to recognise men as victims of rape, there has been a rise in reported cases to the police; however, it has been suggested that the official reported figures represent a small minority of actual cases (Hopper, 2007). Many survivors of sexual abuse never tell or report their experiences (Allagha, 2004); thus, determining a realistic estimate for prevalence rates is difficult. Interestingly, data from self-report surveys of children and adults indicate higher rates of CSA for males than official reporting statistics (Finkelhor, Turner & Ormrod, 2009).

The existing CSA literature stems from a variety of fields, including health, law, politics and mental health, emanating to a broad literature base. With vast differences in the findings of such research, one must muddle through the many different findings and perspectives to gain further clarity. The strong associations between CSA and symptomatology, social cognition, and social behaviours in later childhood and adulthood have contributed to provoking attention to this issue from policymakers and clinicians as well as researchers. Consequently, a vast amount of literature has sought to provide explanations for the impact and effects of CSA in childhood and adulthood. There is some evidence to suggest that children who are sexually abused do not suffer harm either in childhood or adulthood (Rind, Tromovitch & Bauserman, 1998; Yorukoglu & Kempf, 1966); however, the majority of research suggests that CSA can have a variety of physical, psychological, behavioural and interpersonal effects (Maniglio, 2009).

In exploring the literature on the experiences of adult survivors of CSA, one important problem identified concerns the heavy focus of research with female participants, exploring their experiences, coping mechanisms and their healing or therapeutic processes. This gender bias has overshadowed the sexual abuse of males and the subsequent issues relating to it (Rodriguez-Srednicki & Twaite, 2006). Clinical reports pertain to boys as victims of sexual abuse from as early as 1937, yet male CSA still remains a relatively unexplored phenomenon (Mendel, 1995). Not only is there a lack of male-specific research, but there is also a lack of gender comparative research (Dube et al., 2005). This has resulted in ambiguity regarding the long-term effects of CSA in males (Dhaliwal, Gauzas, Antonowicz & Ross, 1996). Bolen (2001) suggests that whilst knowledge in other fields advances in a linear manner:

*The knowledge base of CSA might be considered as bipolar, reflecting the cyclical shifts between depressive phases (in which the knowledge base has been suppressed) and manic phases (in which the developing knowledge has exhibited expansive thoughts) (Bolen, 2001, p. 37).*

Interestingly, this is also reflected in an expanse of literature published in the 1980s. Societal and professional responses to CSA appear equally cyclical (Olafson, Corwin & Summit, 1993). The aim of the current research is to bring together the findings from existing literature and add to these by exploring the perspectives of male survivors. The following sections will introduce the topic of CSA and the literature related to the experiences of adult male

survivors of CSA. A database search using the terms 'childhood sexual abuse' and 'males', 'male survivors of CSA and help-seeking' and 'CSA' revealed a number of studies which will be discussed.

### **The Impact of Childhood Sexual Abuse**

Advances in understanding and developments in the field of CSA have emanated to researchers attempting to quantify the effects of CSA into adulthood. From such studies, numerous psychological, behavioural and social difficulties in adult survivors of CSA have been identified. These include depression and low self-esteem (Valerio & Lepper, 2010), severe post-traumatic stress symptoms (Petrak & Campbell, 1999), substance abuse and suicide attempts (Dube, Anda, Whitfield Brown, Felitti, Dong & Giles 2005), psychiatric disorders (Valerio & Lepper, 2010) and problems with sexual functioning (Rojas & Kinder, 2009). The impact on one's physical health has also been documented (Irish, Kobayashi & Delahanty, 2010; Nelson, Baldwin & Taylor, 2012; Wilson, 2010). Specific medical conditions identified as being associated with CSA include gastrointestinal disorders (including irritable bowel syndrome), neurologic conditions, pain syndromes, and disorders characterised as 'somatisation' (Berkowitz, 1998), as well as higher levels of injurious health behaviours (Koss, Koss & Woodruff, 1991). Furthermore, the psychological effects of sexual abuse, such as eating disorders, suicide attempts, substance misuse and depression, have been found to seriously affect physical health and self-care (Nelson & Hampson, 2008; Nelson, Baldwin & Taylor, 2007).

A number of multifaceted theories have been put forward to explain the long-term impact of CSA. The Traumagenic Dynamic Model (Finkelhor & Browne (1985) postulates that the immediate consequences of sexual abuse relate to four aspects of psychological functioning. These are:

- 1) Traumatic sexualisation – a process by which a child's sexuality is shaped in a developmentally inappropriate way as a result of the abuse.
- 2) Betrayal – the dynamic by which children discover that someone on whom they were dependant on caused them harm.
- 3) Powerlessness – the process in which the child's will, desires and sense of efficacy are constantly contravened.

4) Stigmatisation – the negative connotations, e.g. badness, shame and guilt, which are communicated to the child around the experience and then become incorporated in to the child's self-image.

It is argued that these four processes may be evident in the response of children to other trauma, such as physical abuse and neglect; however, in CSA all four processes are experienced to some degree (Stevenson, 1999).

Briere (2002) proposed that the impact of sexual abuse and neglect on later (i.e. adolescent and adult) psychological functioning can be divided into six areas: (1) negative preverbal assumptions and relational schemata; (2) conditioned emotional responses to abuse related stimuli; (3) implicit/sensory memories of the abuse; (4) narrative memories of the abuse; (5) suppressed cognitive structures involving abuse-related material; and (6) inadequately developed affect regulation skills. There are undoubtedly other abuse effects, which may occur in addition to or without those listed above. One of the earliest impacts of abuse and neglect is thought to be on the child's internal representation of the self and other. These representations generally arise in the context of early parent-child relationships, wherein the child makes inferences based on how he or she is treated by his or her caretakers. In the event of abuse or neglect, these inferences are likely to be negative, for example, inferring the child is bad or at fault, or concluding that they deserve such treatment. Consequently, the child may come to view others as inherently dangerous, rejecting or unavailable. Some theorists refer to these intrinsic self-other perceptions as internal working models (Bowlby, 1982). The impact this can have on later life is that individuals find it difficult to change such perceptions and they become ingrained in their personality or sense of self. These core schemas intrinsically affect the individual's capacity to form and maintain meaningful attachments with other people. According to Alexander (1992), CSA has been associated with insecure attachment styles in adulthood. Insecure attachment can be divided in to three types: Fearful (involving a high need for interpersonal acceptance and affirmation and, yet, avoidant of intimacy); Preoccupied (involving similar high needs for relationships); and Avoidant/Dismissing (involving avoidance of interpersonal attachments and high needs for self-reliance). In addition to attachment-style-related schema, it is clear that childhood sexual abuse can contribute to general relational disturbance. For example, Pearlman and Saakvitne (1995) suggest that trauma during the early years can result in chronic negative expectations and perceptions around issues of safety, trust, self-esteem, intimacy and control.

Existing research on the topic of CSA has predominantly used quantitative methods; however, a number of studies have used qualitative methods to explore experiences of CSA in adulthood (e.g. Courtois, 1988; Dorais, 2002; Gill & Tutty, 1999; Lev-Wiesel, 2000). With particular reference to male survivors of CSA, such investigations identified a number of psychological themes associated with the long-term impact in men, including the experiencing of sexual problems, dysfunctions or compulsions (Lew, 1988; Hunter, 1990); confusion about sexual identity (Anda, Feletti, Walker, Whitfield, Bremner, Perry, Dube & Giles, 2006; Holmes & Slap 1998); denial of the traumatic experience (Nasjleti, 1980); shame (Nasjlete, 1980; Lew, 1988; Hunter, 1990); guilt and self-blame (Lew, 1988); anger, aggression and risk behaviours (Lew, 1988; Hunter, 1990) and difficulties in personal relationships (Kia-Keating, Sorsoli & Grossman, 2010).

Some research argues that the known psychological impacts of CSA are relatively similar for male and female survivors (Finkelhor, Hotaling, Lewis & Smith, 1990), yet other studies have found that female survivors reported higher levels of a variety of symptoms, including anxiety and depression (Banyard et al., 2004). Laumann et al. (1994) reported striking differences between the reports of men and women in a large sample of adults. When asked about the impact on their lives, only 134 of the 166 men in the study responded, and less than half reported that the experience had affected their lives. Many more of the women responded (273 out of 289) and 70 per cent reported that the experience(s) had affected their lives. Nearly all the responses to the follow-up questions indicated that the experience had negative effects. Despite these findings, several authors themselves comment that existing research on CSA has used predominantly female samples (e.g. Banyard & Williams, 1996; Banyard, Williams & Siegel, 2001); thus, comparisons of the impact based upon gender must be interpreted with caution. Furthermore, as Walsh, Fortier and DiLillo (2010) illustrate, there can be substantial heterogeneity in outcomes of CSA, with some adults successfully negating psychiatric diagnoses and living functional lives; thus, childhood sexual abuse cannot be assumed to always cause long-term dysfunction, nor can it be suggested that victim characteristics, experiences and coping styles will not moderate the impact on psychological distress (O'Leary & Gould, 2010).

Contrasting findings in the literature illustrate that there does not appear to be a consistent post CSA syndrome or pattern of effects in the short or long term that applies to all survivors

(Briere & Runtz, 1993). CSA varies in terms of its severity, according to a number of complex and interlinked factors (Putnam, 2003), such as the age and sex of the child, the severity of the abuse and the use of force or coercion (Colton & Vanstone, 1996), the nature of the relationship between the adult and the child (Colton & Vanstone, 1996; Holmes & Slap, 1998) and the frequency and duration of the abuse (Cecil & Matson, 2001). As such, CSA has been considered a complex life experience, rather than a diagnosis or disorder (Putnam, 2003).

### **The Dilemma of the Male Survivor**

Over the past several decades, clinicians and researchers have become increasingly aware of the prevalence of CSA amongst males (Hunter, 1990; Holmes & Slap, 1998). In fact, Bender & Blau (1937) state that it has been recognised for over 60 years that a significant percentage of CSA survivors are male, acknowledging that male CSA is a common and serious problem (Cawson et al., 2000; Finkelhor, 1994; Holmes & Slap, 1998; Putnam, 2003).

Traditionally, rape and sexual abuse are crimes associated with women; thus, many male survivors feel that they are the only ones to have been abused (Sullivan, 2011). In contemporary society, the sexual abuse of males is often denied, misunderstood and trivialised, perhaps due to stereotypes and myths about being male, and the possibility of being sexually abused by either a male or female. Each carries its own negative connotations and burden of incredulity (Spiegel, 2003). The reality of CSA is that neither gender is exempt from either role. The traditional male perpetrator/female victim paradigm, with its mutually exclusive, dichotomous categories, no longer stands, and according to Spiegel (2003), should be updated to a model that allows for the recognition of male traumatisation. Theoretical explanations for CSA, including the 'Seduction Theory' (Freud, 1986), have contributed to further difficulties for the male survivor. Freud (1986) argued that unconscious memories of sexual abuse in infancy may lead to the development of adult psychological disorders. This theory was shortly repudiated, and replaced with the idea of the 'Oedipus' complex, which proposed that female children fall victim to penis envy and choose their fathers as their preferred love objects (Bolen, 2001). Freud's repudiation of the Seduction Theory profoundly impacted the professional response to CSA. For years, those who reported CSA were assumed to be hysterical females recalling fantasised desires for coveted sexual relations with their fathers (Masson, 1984).



The emergence of men as victims of CSA came about as a consequence of the Women's Movement and the creation of 'Rape Crisis' during the early 1970s as an organised campaign against the sexual victimisation of women. The fact that men began to contact Rape Crisis organisations was unexpected and challenged many of the dominant views of the feminist position, which explains sexual violence as a gender-based phenomenon. As Bolen (2001) explains, many policies and programmes designed to protect, identify and treat victims of CSA are failing because they are grounded in historical theories of CSA and fail to take into account the empirical knowledge base. It is therefore unsurprising that male-specific psychological models have not been forthcoming. There are, however, exceptions, mostly from the United States (e.g. Cochran & Rabinowitz, 1996; Good & Mintz, 2005; Kendler, Gardner & Prescott, 2006; Pollack, 2005).

Kingerlee (2012), highlighting a paradox that affects males, proposes that men have often held the most powerful positions in many societies over recent centuries, therefore impacting societal views of men as potential victims. Historically, men do not come from a position of oppression but one of privilege. This position brings its own unique challenge for men in being able to recognise oneself as a victim and having the ability to seek help (Perlick & Manning, 2007; Thompson & Pleck, 1995). What might be considered as a consequence of this, is that relatively little attention has been paid to the psychological functioning of men, particularly in the United Kingdom (Wilkins, 2010).

Although both males and females can be victims and perpetrators of sexual abuse, Bolen (2001) raises the dilemma that for male victims of CSA, there is no separate defined oppressor as the perpetrators are often also male. In cases where the perpetrator is female, there is also confusion as females are supposed to be the nurturing caregivers in society, and are also seen as the oppressed, so cannot be dominant. This contradicts the ideas of males as strong, independent, powerful and in control, which are important stereotypical ideals for men within a patriarchal society. For a man to disclose being a victim of sexual violence, he exposes himself to this contradiction and questioning of his masculinity (Thompson & Pleck, 1995). This can make it difficult not only for men to recognise, acknowledge and disclose sexual abuse, but for others to hear and accept what is being said. This is particularly pertinent in medical and psychological services where practitioners hold negative or misinformed beliefs about men and sexual abuse (Nelson, 2001; Nelson & Hampson, 2008).

## **Men and Disclosure**

CSA is largely a silent crime, often leaving no physical signs and actively hidden by perpetrators. These features make its detection difficult, with increasing importance placed on the victims' disclosure of abuse for investigative and psychological intervention (Allnock, 2010; Finkelhor, 1994). Studies investigating CSA disclosure have identified that the vast majority of children do not seek help or disclose their experience of abuse (Alaggia, 2005; 2010); thus, CSA is often concealed and kept a secret until adulthood (Tang, Freyd & Wang, 2008). Furthermore, evidence from a number of studies highlights that males are less likely to disclose CSA than females (Alaggia, 2004; Hunter, 2011; Sorsoli, Kia-Keating & Grossman, 2008; Tang et al., 2008), underreport their abuse experiences (e.g. Lab, Feigenbaum & De Silva, 2000) and often leave it until later in life to discuss their CSA experiences (O'Leary & Barber, 2008). A review of the literature related to disclosure in male survivors of CSA emphasises that ten years on, little advancement has been made in this area. In 1998, Holmes and Slap reviewed more than 169 empirically based studies and concluded that 3 in 4 adolescents (71%) and men (77%) sexually abused prior to the age of 12 never reported their abuse experience(s) until adulthood. More recently, Herbert, Tourigny, McDuff and Joly (2009) reported that approximately one in every 5 survivors had never disclosed abuse at the time it occurred, with men more likely not to have told anyone than women. Several societal norms may contribute to this underreporting, including the expectation that boys should be dominant and self-reliant, the notion that early sexual experiences are a normal part of boys' lives, fears associated with homosexuality and pressure on males not to express helplessness or vulnerability (Nasjleti, 1980; Romano & De Luca, 2001). For many male survivors, seeking help is unimaginable and 'the consequences of disclosure are perceived as worse than the consequences of non-disclosure' (Holmes, Offen & Waller, 1997, p. 77). Furthermore, there is evidence to suggest that men continue to struggle to find the support they need even after disclosing CSA (Sorsoli et al., 2008).

The Child Sexual Abuse Accommodation Syndrome (CSAAAS) proposed by Summit (1983) described typical reactions of children who are sexually abused, and provides an explanation for why many children (and adults) do not disclose sexual abuse. The syndrome is composed of five categories, two of which define basic childhood vulnerability, and three of which are sequentially contingent on sexual assault: (1) secrecy; (2) helplessness; (3) entrapment and accommodation; (4) delayed, unconvincing disclosure; and (5) retraction. The first of the preconditions, secrecy, emphasises the explicit and implicit notion of keeping the abuse a

secret, often enforced by the perpetrator. This is frequently accompanied by threats such as 'this is our secret; nobody will understand; if you tell anyone then I will kill you/family member' etc., which further encourage the child to remain silent. The second precondition is helplessness. Summit (1983) explains that the abused child's sense of helplessness is an outgrowth of the child's subordinate role in an authoritarian relationship in which the adult is entrusted with the child's care, such as the parent-child relationship. The third aspect of the syndrome explains how sexual abuse continues. The child feels trapped by the situation (entrapment), and this can result in the behaviour of accommodating the abuse (accommodation). Because of the child's helplessness, the only option left is to survive by accepting the situation. Adults often find it hard to believe this when looking back, because they lack the child's perspective (Summit, 1983). The fourth aspect is delayed, conflicted and unconvincing disclosure. Most victims never disclose the sexual abuse, and many assume that they will not be believed or taken seriously if they do disclose. The fifth and final aspect is retraction. Summit proposed that a child will often reverse or retract what they say about their experiences. The post-disclosure family situation tends to confirm the victim's worst fears, which encouraged secrecy in the first place, i.e., his mother is disbelieving, his father threatened with removal from the home, and the blame for this state of affairs placed on the victim. The accommodation syndrome is proposed as a model for use by clinicians to help improve understanding and acceptance of the child's position in the complex and controversial dynamics of sexual victimisation (Summit, 1983).

A study by Sorsoli et al. (2008) provides valuable insight into the ways in which gender affects victim disclosure. For men, disclosing abuse perpetrated by a man is extremely difficult and shameful, raising questions about their sexuality and concerns about homophobic attitudes from others (Gill & Tutty, 1997). How boys are socialised (especially regarding sexual behaviour) is also thought to contribute to delayed disclosure (i.e. longer than one month) in male survivors (Sable, Danis, Mauzy & Gallagher, 2006). Alaggia and Millington (2008) highlight disclosure for men as being 'challenging venture in the face of socialized gender roles that promote images of men as immune to victimization or as inadequate when victimized' (p. 272), proposing that patriarchy is just as harmful for men as it is for women. Etherington (1995) identified a range of problems amongst men who have been sexually abused, including difficulties in reporting their abuse due to fear of judgement, shame and guilt. Offering support for these findings, Dhaliwal et al. (1996), Putnam (2003) and Tang et al. (2008) found that there is a sense of stigma and shame attached to CSA. As pervasive as CSA

is, many survivors grow to learn that their experiences are best kept a secret (Anderson, Martin, Mullen, Romans & Herbison, 1993; McNulty & Wardle, 1994; Ullman, 2003).

Much of the disclosure literature has focused on whether or not disclosing abuse is beneficial, with studies yielding mixed results (Ullman, 2003). Disclosure response factors have been examined from the perspective of the victim, with findings emphasising that the most helpful reactions to a disclosure were responses such as being believed and offered support, whilst the least helpful responses were being blamed, treated differently, controlled, or encouraged to keep the abuse a secret (Ullman, 2000). One important conclusion from this literature is that it is not necessarily the act of telling, but rather how others respond that can be healing in some cases and hurtful in others (Harvey, Orbuch, Chwalisz & Garwood, 1991; McNulty & Wardle, 1994; Ullman & Filipas, 2005). O'Leary et al. (2010) found that participants who had discussed the abuse (rather than just told someone about it) experienced fewer mental health symptoms. Thus, it seems that the first disclosure experience has significant implications for successful outcomes in seeking help. Studies comparing child and adult disclosures of CSA have found that survivors have rated disclosures occurring in adulthood as being met with more positive social reactions and as being more helpful than disclosures that occurred in childhood (Lamb & Edgar-Smith, 1994; Roesler, 1994); however, such studies have relied on retrospective reporting from victims to draw conclusions about how others might respond.

Ray (2001) conducted a mixed model study using semi-structured interviews to explore how the after-effects of sexual abuse from male survivors' perspectives might help clinicians identify males with possible histories of CSA. Findings validated previous qualitative research, with males reporting difficulty in forming relationships; powerlessness; isolation; and being alienated from others. Fifty-two per cent of the participants reported addiction to drugs or alcohol, and sixty per cent had sought therapy for suicidal ideation and depression. Such findings highlight the need for psychologists to consider the possibility that unresolved distress may be masked by manifestations of other difficulties, i.e., substance use. For those providing therapy, these data make clear how necessary it is that, as soon as possible after developing rapport, clinicians ask directly about sexual abuse in non-shaming ways. It seems likely that the issue of childhood abuse may need to be raised more than once, as several of the men in the sample had been asked and did not initially disclose. Furthermore, Holmes et al. (1997) state that without direct questioning, most clients, and almost all men, do not

initiate disclosure. Furthermore, Reviere (1996) notes that, historically, professionals put forward the idea that children frequently report false accounts of abuse, a factor which further impacts one's decision to disclose.

Allnock (2010) argues that, in many cases, disclosure is vital to early intervention, yet although disclosing CSA can lead to relief and social support; it may also lead to further distress (McNulty & Wardle, 1994). Consequently, researchers have concluded that disclosure, rather than always being beneficial, is an evolving and complex phenomenon (Ullman, 2003; Ullman, Foyes & Tang, 2010). Evidence indicates the importance of disclosure characteristics in predicting the long-term effects of CSA in adulthood in samples of women (Jonzon & Lindblad, 2005); however, whether such findings can be generalised to males is unknown. It would therefore be useful to understand how men have disclosed CSA. Examining potential obstacles to disclosure would enable us to see where any barriers could be removed, perhaps increasing the likelihood for intervention during childhood.

### **Masculinity and Male Socialisation**

The experience of sexual abuse brings forth issues that show how stereotypical views of both genders, though based in a reality, are not absolute and are unhelpful to the recovery of both men and women. To understand the impact of CSA on men's identification with masculinity and male roles in society, it is important to consider the meaning of masculinity.

Connell (1995) posits that the term 'masculinity' is considered a social construction understood as a configuration of gender practices, referring to male bodies, either directly or symbolically but not determined by male biology. Masculinity can also be defined as the actions, attitudes and values that identify someone as being a man (Coutenay, 2000). Connell proposes a hierarchy of types of masculinity, with hegemonic masculinity (representing the dominant, most powerful form, 'the male role') being the form by which most other masculinities become measured and represented as subordinate to. Although not considered as fixed character types, different masculinities represent configurations of practice that men move within and between at different times and in different situations (Connell, 1995). Therefore, masculinity is not fixed; different categories of masculinity exist and male identities can change and continually reform, and the impact of this enables men to situate themselves, and be situated amongst different positions (for example, displaying hegemonic masculinity at work, but not in other areas of life). Expanding on this view, research exploring

the impact of masculinities on health behaviours (e.g. de Visser & McDonnell, 2013) showed that participants with more traditional gender role beliefs had stricter beliefs about the masculinity of various health behaviours. This illustrated the impact that aspiring to live up to masculine ideals can have on health behaviours. Existing literature has revealed that men are frequently hesitant to search for help because of the notion of gender-role socialisation (Chrome, 2006; Robertson, 2003). Furthermore, Robertson (2003) associates gender-role socialisation with the fact that men are less likely to seek therapeutic interventions such as psychotherapy than women. In a study exploring preferences for support amongst men who avoid counselling, men with highly masculine attitudes reported a preference for alternative helping formats over traditional ones. The author proposes that by offering alternative interventions such as workshops, or counselling interventions that are more congruent with male socialisation, more men might be willing to engage.

Growing up with the impact of gender socialisation gives messages to boys about how to act and respond in certain situations. Definitions of heterosexual sexuality expect men to be the pursuers of sex and women to be the pursued (Weiss, 2010); therefore, males who have experienced early victimisation are often torn between their desire to accept traditional masculine roles or risk of being labelled as effeminate if they reveal that they have been abused (Kia-Keating et al., 2005). Further fears included the thoughts that they had been chosen by their abuser because of their own hidden homosexual traits or that they would be labelled homosexual if others knew about their experiences (Kia-Keating et al., 2005). Similarly, Both Alaggia (2005) and Holmes and Slap (1998) found that men who had been sexually abused by same-sex perpetrators found it harder to disclose CSA or seek psychological intervention because of the perceived threat to their masculinity

Weiss (2010) described how prevailing societal assumptions that men should be strong and masculine let men down when they consider seeking help. Such assumptions have contributed to the idea that a man cannot be sexually abused, resulting in a dilemma: report the abuse and risk being stigmatised, or keep quiet (Yarrow & Churchill, 2009). This is explained further by Goodwin (2005, cited in Lemelin, 2006) as part of the typical male socialisation process, which requires men to aspire to certain standards of masculinity. Such standards are imposed by society, reinforced by peers, family and the community and also by men themselves. The conflict of striving to meet this masculine idea and the disparity of the real lives of males creates a “gender role strain”, which can lead to a myriad of issues for boys

and men. Furthermore, clinicians have proposed that male socialisation can force men to deny or minimise experiences of abuse as well as their subsequent suffering, thus exacerbating symptoms and impacting recovery (Lisak, 1994; 2005). Ouellete (2009) suggests that the phenomenon of male abuse is incompatible with current dominant discourses associated with masculinity and, as such, proposes that this stereotype is so ingrained in our culture that it not only affects society, but also professionals and even male survivors of sexual abuse themselves. In addition, Lew and Hoffman (2000) further state that this discourse has no room for men as victims. Gender role socialisation has a clear impact on both the physical and mental help-seeking behaviour of men (Mansfield, Addis & Mahalik, 2003). When a boy is taught the masculine ideology that 'real' men do not show emotion and do not ask for help, it influences his view of help-seeking. When he then encounters health issues later in life, he may be less likely to admit his problems or seek help for them (Mansfield et al., 2003). Research by Robertson (2003) expands on the relationship between masculinity and men's health behaviours by exploring how men's connection to sport, fitness and competitiveness can be used in health promotion initiatives to introduce facets of health (Robertson, 2003). The challenge for health professionals is to identify potential vehicles for the provision of support, whilst not excluding particular groups of men. For example, the use of sport as a vehicle for health work with men might appeal to some, but not others. Whilst the availability of services and resources for female survivors has helped to reduce the stigma of being sexually abused and assisted women to come forward and access help, this has not been the case in the male population, according to Mendel (1995). Therefore, research investigating the barriers to help-seeking and engaging in therapeutic interventions is needed.

### **Male Survivors and Coping**

Coping refers to a range of diverse cognitive responses and behaviours used to manage the internal and external demands of a stressful or threatening situation (Folkman & Lazarus, 1980). Cognitive coping strategies include attempts to change one's perception of a situation, whereas behavioural coping includes actions taken to reduce the effects of the stressor (Walsh et al., 2010). Coping effectively with sexual abuse is likely to occur in phases over time and involve the use of different strategies (Horowitz, 1986). Specific types of coping have been associated with negative and positive health outcomes following CSA. Walsh et al. (2010) carried out a theoretical review of literature on adult coping and CSA which indicated that emotion-focused coping (regulating one's emotions rather than the stressor) and

avoidant coping (dissociation, denial of or disengaging from memories or feelings related to the stressor) used immediately following the event and over time are associated with psychological distress. Putnam (2001) postulates that dissociation is an array of complex psycho-physiological processes that create various defences across the domains of the self, and confound the ability to access memories and knowledge, and disturb the capacity to integrate behaviour. Whilst this can enable one to cope at a certain time, dissociation can be thought of as a maladaptive defence mechanism. The aim is to protect the psyche, which may assist the individual in escaping reality, enabling detachment and depersonalising from the self from the traumatic event. O'Leary (2009) examined coping strategies in men who were sexually abused in childhood to ascertain their relationship to clinical diagnoses. He found substance use was the most common strategy used by the participants. Similarly, Wolfe, Francis and Straatman (2006) found substance abuse was a common response to control distress and discomfort. In contrast, approach-coping (e.g. engaging in active strategies to address the stressor), receiving social support and finding meaning in the abuse have been associated with positive outcomes (Brand & Alexander, 2003; Merrill, Thomsen, Sinclair, Gold & Miher, 2001). Spirituality, social support and self-determination have also been found to be common positive influences in helping individuals cope with their childhood trauma (Davis, 2002; Dervic, Grunebaum, Burke, Mann & Oquendo, 2006). Similarly, O'Leary (2009) emphasised the benefit of social support and its association with better psychological functioning.

The notion of the wounded healer is also relevant to coping. The wounded healer is defined as an archetype that suggests the pain of the healer is the source of their power to heal others (Zerubavel & Wright, 2012), and that the healer's own experiences form the foundations of their empathy with clients and their 'wounds'. This is particularly relevant for survivors of sexual abuse, who can find it both healing and rewarding to help others work through their difficulties. Grossman, Sorsoli and Kia-Keating (2006) found that male participants described themselves as having been committed to helping others, particularly those perceived as vulnerable, in order to make meaning of their own experiences and difficulties.

### **Making Sense of Childhood Sexual Abuse**

The findings from previous research have documented the difficulties survivors encounter in trying to make sense of what has happened to them (Isely, Isely, Freiburger & McMackin,



2008), specifically, identifying if their experiences constitute sexual abuse. Isely et al. (2008) utilised in-depth interviews to conduct a qualitative analysis of how clergy-perpetrated CSA affected the adult psychological and psychosocial functioning of nine men. Only one male reported disclosing the abuse at the time of abuse. The authors stated that 'at its initial occurrence, participants did not identify the violence against them as 'sexually abusive' and had difficulty in naming the abuse', thereby providing important insights for clinicians, namely that they should not assume that either a child or adult survivor necessarily understands that the sexual contact was abuse. It was considered that understanding the abuse as adults appeared to produce some relief from the painful feelings that remained deeply embedded within the participants. Draucker and Martsof (2008) support this with findings which revealed that participants benefited from understanding their abuse experience(s). The challenges identified with making sense as adults included the fact that the abuse occurred in childhood, was often perpetrated by an intimate other, involved sexual activity for which they were not prepared, and was shrouded in secrecy.

The authors propose that 'healing' involves gaining an understanding of the nature of the abuse and why it happened to them, in particular, whether they were to blame and what effects it had on their lives, and how (if relevant) it contributed to their current problems. They describe that the participants figured out that the CSA was abusive regardless of its circumstances (for example, their age at the time of the abuse), how they were engaged in the abuse (e.g. coercion, force), or their response to it (e.g. pleasure, disgust, arousal, terror). They also developed an appreciation of how their current distress was related to the CSA and its effects (Draucker & Martsof, 2008).

### **Resilience and Recovery**

The terms 'resilience' and 'recovery' have been discussed in existing CSA literature as related but distinct concepts (Chouliara, Karatzias & Gullone, 2013). The concept of resilience relates to the ability of adults in otherwise normal circumstances who are exposed to potentially traumatic events, such as the death of a close person, or a violent or life-threatening situation, to maintain relatively stable, healthy levels of psychological and physical functioning. Developmental theorists have argued that resilience to adverse childhood events results from a cumulative and interactive mix of genetic, environmental and protective factors; thus, resilience is considered as more than the simple absence of psychopathology (Rutter, 1999; Werner, 1995). Recovery, as discussed in the CSA literature,

is considered a wider concept that relates to symptom remission and the survivors' personal processes and experiences over time in order to reach a meaningful sense of life post abuse (Chouliara et al., 2013).

Kia-Keating et al. (2005) sought to investigate gender role socialisation and the experience of CSA in men who identified themselves as 'resilient survivors'. Sixteen men showing signs of resilient adaptation to adult life completed qualitative in-depth interviews, analysed with Grounded Theory (Strauss & Corbin, 1990). The aim of the study was to develop a theoretical framework explicating the ways in which the participants endeavoured to resolve these conflicts as part of their recovery process. Participants repeatedly described both containing and resisting traditional masculine roles in their paths towards recovery. An interesting finding was that a proportion of the sample (seven out of sixteen) who reported being homosexual stated that learning to 'resist' the need to be masculine increased their resilience.

A phenomenological investigation by Kia-Keating, Sorsoli & Grossman (2010) examined relational challenges and the processes by which a sample of sixteen male survivors improved their capacity for seeking and participating in supportive relationships over time. Again, data were analysed using Grounded Theory, and similar to the previous study, initial codes were developed based on codes identified in a study of resilient female survivors (Grossman, Cook, Kepke & Koenen, 1999). Mechanisms associated with positive adaptation were identified, including engaging in safe relationships; gaining a sense of belonging by locating a community of others with shared experiences; and learning healthy ways to manage relationships through setting boundaries, controlling anger, building trust and developing intimacy. Due to the participants' boundaries being violated in childhood, all of the men reported needing to learn what it meant to set limits and how to do this. Trauma-informed therapy was highlighted as a helpful context for facilitating this learning. A criticism of both of these studies concerns the data analysis (in particular, the coding process), which was conducted based on codes identified in prior research using female samples. Firstly, this does not appear consistent with the principles of Grounded Theory in which the data is not driven by previous findings; secondly, using codes identified in a female sample would not allow for new information to emerge from the data collected.

More recently, Marriot, Hamilton-Giachritis and Harrop (2013) reviewed fifty English language studies from 1991-2010, investigating resilient outcomes for people with a history

of CSA and implications for practice. Many papers presented similar findings associated with resilience in survivors of CSA, including the identification of familial support and stability, peer friendships, appropriately timed social support, academic success, spirituality and a sense of community. The authors conclude that health promotion initiatives and social policies and programmes can improve resilient outcomes for people with a history of CSA, using both individual and systemic interventions.

The concept of recovery is different for each survivor. A study by Roberts and Wolfson (2004) suggests that those who seek help are not solely concerned with symptom remission, but placed importance on other aspects, such as achieving improvements in other aspects of their lives, for example, being able to return to work or establishing and maintaining personal relationships (Lelliott, 2000). Meaningful recovery represents a long-term process or a journey (Chouliara et al., 2013), which emphasises the importance of peer support, meaningful activity, employment, as well as maintaining social networks and activities and having the chance to contribute or give back in some way (Repper, 2000). Other authors have focused more on overcoming the psychological effects such as shame; for example, Draucker and Petrovic (1996) proposed a framework of healing for male survivors of sexual abuse based on the metaphor of 'escaping the dungeon' to reflect how male survivors experienced the powerlessness and shame associated with their experiences of sexual abuse. Healing involved breaking free from the dungeon, living free and freeing those left behind. Although such models have been presented in the literature, there is a lack of empirical evidence of their efficacy in facilitating healing or recovery in male survivors of CSA. Further research is therefore necessary to determine if these methods are effective and useful for male survivors of CSA.

### **Help-Seeking, Therapeutic Interventions and Support for Male Survivors**

Professional intervention is considered an effective and important factor in the recovery of survivors of CSA (Tingus, Heger, Foy & Leskin, 1996; Warne & McAndrew, 2005); however, Sorsoli et al. (2008) note that many survivors, particularly males, are reluctant to seek help and many do not receive any intervention or support (Tingus et al., 1996). Survivors of sexual abuse in general have been found to have a difficult time initiating therapy, because they are unable to believe that anyone would want to help them (Krause, 1997). It has therefore been acknowledged that accessing and receiving help is a complex and difficult issue (Gavey, 2003).

There are a small number of specialist CSA agencies in the UK (e.g. 'Survivors UK' and 'NAPAC', both based in London) providing information, telephone support and counselling for men. There remains, however, a scarcity of published research which considers the experiences of male survivors who seek help for issues related to CSA, thus demonstrating the gap between theory and practice. It remains unclear if, and how, males seek and receive support, what factors influence the quantity or quality of the support obtained, whether male CSA survivors perceive their needs and service provision in the same way as clinicians, or, indeed, whether their needs are met in clinical settings (Draucker & Petrovic, 1997).

Acknowledging and disclosing the memories, thoughts, and feelings associated with abuse and trauma have long been viewed by clinicians as important aspects of healing (e.g. Harvey et al., 1991), particularly for those who develop Post-Traumatic Stress Disorder (Finkelhor, 1984). Yet, in comparison to the literature available on therapeutic interventions for female survivors of CSA, much less exists on male experiences of support, therapy or alternative interventions. Researchers have suggested reasons for this disparity, one being that, historically, counselling for survivors of CSA has been aimed at females using models which developed out of feminist theory, therefore addressing the unique pressures and issues that women may face within a patriarchal society (Bolen, 2001). For male survivors, there is no such history of comprehensive research, and subsequent responses to developing a model of service delivery have not been forthcoming. Draucker and Petrovic (1997) suggest that by disregarding the male's perceptions and experiences pertaining to their sexual abuse, and thus by working solely from a female-based model, counsellors may increase the male survivor's feelings of isolation and alienation.

Research is growing on men as victims of sexual abuse; however, much of this has focused on prevalence and effects. Although this has helped to highlight the existence of the male survivor, there is no consensus or best practice guidelines on delivering services that can inform agencies that offer services to this client group. Findings of limited previous research in the area revealed that positive experiences of talking therapy focused mainly on the development of an equal, open, respectful and non-judgmental therapeutic relationship (McGregor, Thomas & Read, 2006; Phillips & Daniluk, 2004). Survivors also emphasised the importance of knowledge and awareness of health professionals about CSA-specific issues, as well as trauma-related issues (Schachter, Radomsky, Stalker & Teram, 2004). Survivors' negative experiences of therapy included professionals taking a sexual interest in survivors,

being passive or unresponsive and prescription of heavy medications with little consultation on this decision (Koehn, 2007; Nelson, 2009). Research on survivors' experiences of different theoretical approaches is also limited. Crome (2006) asserts that although there is room for debate, the practical approach to providing therapy and the principles of treatment are similar for both male and female survivors of CSA and proposes that decisions of practice approaches should be client-led. Nelson (2001) and Dale (1999) propose that it is not the particular theoretical approach or degree of qualification which is most important but the personal empathy and skills of the practitioner (Nelson, 2001; Dale, 1999). Other authors have suggested that different therapeutic approaches may provide alternative benefits for different stages of recovery (Edmond, Sloan & McCarty, 2004; Feinauer, Bringham & Provo, 1989; Nelson & Phillips, 2001). Friedrich's (1995) integrated approach to treatment, exploring domains of attachment, dysregulation and self, suggests a variety of strategies to help overcome the effects of CSA, including difficulties with distrust of others and forming close relationships, stigmatisation and powerlessness, and the ability to regulate emotions. Emotional dysregulation is a term used to refer to a poorly modulated emotional response, and may be referred to as mood swings or inability to manage different emotional states. Possible manifestations of emotional dysregulation include anger outbursts or behavioural outbursts, such as destroying or throwing objects, aggression towards self or others and threats to kill oneself. Emotional dysregulation can lead to behavioural problems and can interfere with a person's social interactions and relationships at home or place of employment. Given the multitude of problems that can be associated with CSA, effective treatment may require a strategically staged multimodal approach (van der Kolk, McFarlane & van der Hart, 1995), targeted at managing the intense affect, modifying the distorted self-schema and resolving the trauma impact. The number of males who receive such intervention is unclear. Considering the estimated high prevalence of sexual abuse and limited numbers of men who seek help, it is possible that many male children and adults endure prolonged suffering and many never receive necessary intervention. Yarrow and Churchill (2009), exploring counsellors' and psychologists' experiences of working with male survivors, propose that the topic of male CSA should be studied in more depth in order to respond to the needs of this often neglected client group.

Alaggia and Millington (2008) elaborate, highlighting the importance of therapists contextualising survivors' experiences within an understanding of their lives and applying this understanding to practice:

*In the current era of evidence based practice, although it is important to incorporate approaches with demonstrated effectiveness, more than ever we need to be reminded of the importance of the context of our client's lives throughout the therapeutic process [...] Through a deepened understanding of the lived experience of sexually abused men, their narratives offer directions for therapy (Alaggia & Millington, 2008, p. 272).*

Although evidence-based treatment models exist, they predominantly represent small-scale, clinic-based studies with limited follow-up. Large-scale research trials with longitudinal follow-up conducted in community settings to determine how well these models work in the real world are needed. Putnam (2003) highlights that preliminary research indicate that Cognitive Behavioural Therapy (CBT) is effective for some of the symptoms associated with CSA; however, Putnam emphasises that evaluations to date are limited. It therefore becomes important to remember that in dealing with sexual abuse, one size does not fit all. Regarding the distinctiveness of male childhood sexual abuse, further research needs to be conducted in order to formulate effective treatment programmes and therapeutic interventions that are sensitive to gender specific issues that may arise for such men (Romano & De Luca, 2005, p. 41).

Another complicating factor potentially impacting men seeking help, illustrated by Nelson (2001), Nelson and Hampson (2008) and Day, Thurlow and Woolliscroft (2003), is that mental health professionals (e.g. nurses, psychiatrists, occupational therapists, counsellors, psychologists) report feeling uncomfortable, incompetent or unsupported in working with survivors and are reluctant to open 'a can of worms' (especially with male survivors). Furthermore, a study of mental health professionals' attitudes and practices regarding male CSA by Lab, Feigenbaum and De Silva (2000) found that the majority of professionals rarely enquired about sexual abuse in male patients and that staff were generally using ineffective and unsystematic methods of enquiry when they did ask (Havig, 2008). In addition, knowledge of prevalence rates of male sexual abuse was extremely variable: two thirds of staff reported having had no specific training in the assessment or treatment of sexual abuse, and a similar number did not feel sufficiently trained to be able to inquire about sexual abuse in male patients. McNay, Marland and Hampson (2012) propose that health professionals need to develop a confident, safe, objective and self-aware approach to responding to initial

disclosure and dealing with on-going referral if necessary, and highlight that the approach of health and social care workers is often based on misunderstanding, prejudice and fear. Various studies have argued that health professionals, such as nurses, therapists and GPs, have a responsibility to inquire directly about sexual abuse in non-shaming ways (e.g. asking questions such as 'did anyone ever do anything to you sexually that you might not have wanted them to do?') (Lab et al, 2000; Sorsoli et al., 2008; Valente, 2005).

### **Methodological Concerns and Limitations of Existing Research**

The CSA literature has been criticised with regard to methodological issues (Violato & Genuis, 1993). Reviewing published research, there is a predominance of studies using female samples, including recent research exploring treatment interventions for CSA, such as mindfulness (Kimbrough, Magyari, Langenberg, Chesney & Berman, 2010) and inpatient treatment (Jepsen, Svagaard, Thelle, McCullough & Martinsen, 2009). Criticisms have been raised concerning the fact that much of the data elicited and analysed stems from investigations into the dynamics and effects of CSA as they relate to female children perpetrated by adult men (Roane, 1992). This further reinforces the view of men as the perpetrators of sexual violence rather than the victims. The limited research with mixed samples tends to have much higher ratios of female to male participants (e.g. Hunter, 2009; Phanichrat & Townshed, 2010; Draucker & Marsolf, 2008). A recent meta-summary by Martsof, Draucker and Cook et al. (2010) of 31 published qualitative studies with a focus on CSA survivors' use of professional services further emphasises the disparity of research studies. From a combined sample of 1030, only 46 males participated.

A review by Chouliara, Karatzias, Scott-Brien, Macdonald, MacArther and Frazer (2012) summarises and evaluates evidence regarding therapeutic services for CSA from the survivors' perspective. Studies of quantitative, qualitative and combined methodology were included if they were a) published in peer-reviewed journals after 1980; b) published and disseminated in English; and c) they examined the views and experiences of psychotherapy/counselling services of CSA survivors, as stated in the title or abstract of the paper. From an initial retrieval of 378 articles, nine met the inclusion criteria for the review and only two of these were UK-based and neither had been published in peer-reviewed journals, but disseminated locally at conferences. Of the studies included, only two were conducted with male survivors (Draucker & Petrovic, 1997: USA; Nelson, 2009: Scotland). Not only does this illustrate the lack of literature exploring male survivors' views, but it

suggests that from 1997 to 2013, research exploring males' views of services is limited. The authors comment on this distinct lack of research and emphasise that the findings of the reviews were limited due to selection bias, inconsistencies in recruitment and procedure, ill-described samples and analysis and therefore the findings must be interpreted with caution. The reviewed research was also lacking in consistency, with wide variability in methodology and focus, which make findings difficult to compare. Further criticisms concern the researcher's own background. A number of the studies were conducted by therapist-researchers (Chouliara, Hutchinson & Karatzias, 2009). Whilst this contributes to valuable research, one must consider the issue of dual relationships with clients and participants and the potential impact of the therapist's background and professional experience on the data collected and analysed. Researchers must ensure reflexive practice to ensure their findings are not biased in any way. Despite the challenges of conducting research in the area of CSA, it is vital that researchers continue to utilise opportunities to learn more and educate others on the topic of CSA.

Further limitations include the characteristics of the samples; many studies are limited to samples with largely Caucasian participants. Given that cultural factors are important in defining CSA and adult psychological dysfunction (Carey & Wincze, 2001), the use of narrow samples limits our understanding of the impact of CSA on males from other cultures and backgrounds. There are also issues in defining and measuring CSA (Violato & Genuis, 1993). How CSA is conceptualised and measured is fundamental to the validity of inferences made from the data. Bolen (2001) highlights that some studies provide no definition of sexual abuse, whereas others only apply a definition of abuse when the age difference between the victim and the perpetrator is five or more years. In addition, Bolen states that many people struggle to see sexual abuse when there is pressured sex between teen male peers; when adult females expose themselves to boys; when adult females use the services of teen males working in prostitution; or when an adult male or female shows pornography to a boy. Even if there is agreement about some of these categories when boys are involved, once a male reaches his teenage years, Bolen suggests that our perceptions can change, reflecting a double standard, whereby different principles are considered acceptable in different situations. This itself can have a significant impact on the interpretation of research findings. It is not uncommon in studies of males abused by females to find claims that participants did not see the sexual contact as 'abuse' and viewed it as a neutral or positive experience (Denov, 2004). Those reading these studies who accept these accounts at face value might



assume that there were no negative or harmful effects. When making this assumption, we forget that males are socialised to minimise the impact of being victimised, especially if the abuser was a female (Bolen, 2001).

Findings from small qualitative studies cannot be generalised beyond their immediate setting, and comparative studies are scarce in the literature. Due to limits of generalisability, the results of such research should be treated with caution. In addition, the majority of research uses retrospective designs, requiring dependency on recall which may have become distorted over the years. Prospective research offers the chance of obtaining more reliable information. The use of qualitative interpretation has also been questioned. Although attempts are made by researchers to carry out analysis objectively, bias might have implicitly prevailed in the interpretative process, in particular, for authors who have conducted similar research previous with female survivors (e.g. Grossman et al., 2006; Kia-Keating et al., 2005; Sorsoli et al., 2008). Bolen (2001) emphasises the importance of analysing the literature, considering the potential limitations and not taking a study's findings at face value. Alaggia and Millington (2008) add to this by highlighting that research on male CSA is still in its infancy and must be interpreted with caution.

From the above literature, a number of questions were raised for theoretical consideration. Broadly speaking, what contributes to male CSA survivors' recovery, and are there ways to encourage or provide these factors through clinical strategies? What other factors are implicated in help-seeking? An extensive search of the literature has failed to identify recent UK-based qualitative research that examines these questions in males. This study aims to address these gaps.

### **Male CSA and the Relevance to Counselling Psychology**

According to Anderson et al. (1993), survivors of CSA often disclose their abuse histories after attending therapy for other reasons and many do not understand how CSA can continue to impact them in adulthood. Those who do seek therapy may present with a complex array of difficulties (Berliner & Elliott, 1996), or co-morbid symptoms that make treatment planning more complex and may therefore require concurrent or sequential use of more than one therapeutic modality (e.g. substance-use treatment followed by exposure therapy) (Richard & Lauterbach, 2007). Factors such as these must be taken into consideration when considering options for survivors seeking help. Counselling Psychologists have a role in contributing to

this field in both research and practice. It is highly probable that Counselling Psychologists will come into contact with clients with histories of CSA during their careers. It is therefore imperative that they are knowledgeable of this topic area and can acknowledge and identify help-seeking if advances in intervention and treatment are to be made.

Holmes et al. (1997) note that in the past, professionals have often failed to hypothesise that their male clients may have been abused, and do not create the conditions that would enable males to talk about the abuse. Counselling Psychologists are trained in a variety of approaches and integrate traditional scientific psychology and research with psychotherapeutic concepts and theory and seek to deliver therapy that is committed to the well-being of each individual. Counselling Psychologists aim to facilitate personal growth and interpersonal functioning, enabling individuals to overcome problems, improve well-being and live fulfilled lives. With a focus on the therapeutic relationship as essential to therapy, Counselling Psychologists can offer the conditions and environment for survivors to disclose sexual abuse and work on their difficulties.

Information provided on the websites run by Survivors UK and NAPAC (National Association of People Abused in Childhood) highlights the increase in demand for services to reach men who do want support. Having worked with male survivors and learned of their difficulties accessing support, the researcher was keen to learn more and further understand the challenges that men may face in help-seeking following the trauma of CSA. Trauma-based disorders are not only pervasive and multidimensional, but tend to be treatment-resistant (van der Kolk, Roth, Pelcovitz, Sunday & Spinozza, 2005). An understanding of the dynamics of CSA is therefore relevant to the practice of counselling in virtually all settings and areas of specialisation. Counselling Psychologists emphasise the importance of the therapeutic relationship, which has been found to be a key factor for survivors engaging in help. In addition, exploring in depth the experiences of male survivors of sexual abuse will inform Counselling Psychologists of aspects that may be worthy of attention for therapeutic intervention in clinical practice.

### **Rationale for the Current Research**

The past two decades have observed an increase in numbers of boys and men who have broken their silence and disclosed CSA, yet there remains a distinct lack of information and expertise about how to address their needs in terms of policy, practice, prevention and

interventions across the life course. Some progress is evident, but in many areas it remains difficult for male survivors of any age to access the support they need. Services are scattered, with little funding available. In the United Kingdom, the government allocated £225,000 to a male victim fund for 2011-2013, which represents just over half a per cent of the £40m that has been ring-fenced up to 2015 for specialist local domestic and sexual violence support services, rape crisis centres and the national domestic violence helplines (Sullivan, 2011). The male victim fund has now been allocated to 12 local charities across England and Wales, but only one award went directly to a dedicated charity for male victims. The other charities to secure funding include a number of local services specialising in work with female victims. This presents a dilemma for individuals seeking support and intervention and professionals who work with male survivors of CSA. In fact, Nelson (2009) highlights that many professionals report feeling deskilled and as isolated as the men they are attempting to support.

The range of potential adverse adult outcomes of CSA is extensive and there appears to be no unique pattern to these long-term effects (Wilson, 2010). Understanding men's experiences and elucidating in greater detail how male survivors seek help for CSA in adulthood, including any barriers that may have been encountered, has important clinical implications (Gartner, 1999). Direct input from survivors is one way of identifying the most appropriate forms of support and intervention, and of obtaining the best information on what might encourage boys and men to speak out about what has happened and ask for help. Survivors themselves have the clearest understanding of why it is hard to do this. Knowing when and how men decide to seek help may deepen understanding as to how to support those men in the initial stages of help-seeking and is a vital step towards understanding what may help or hinder this process. It would also be informative to inquire about what type of services men would use in practice. Their perspectives and experience may therefore help to identify the kinds of support that is needed, how this might be best accessed and at what stages across the life course. There are currently few studies, particularly in the UK, of male survivors' own perspectives to guide policy and practice. There remains a need to bring together theory, practice and ideas around the delivery of services to male survivors. The current research aims to begin this process by gaining an in-depth understanding of male experiences so as to provide a clearer picture of this group.

Existing qualitative research with survivors of CSA has predominantly used Discourse Analysis (DA) or Grounded Theory (GT) (e.g. Draucker, 2008; Draucker & Petrovic, 1996; Sorsoli et al., 2008). Briefly, DA is concerned with language, in particular, how individuals accomplish personal, social and political projects through language. Verbal behaviour is considered as a direct means of uncovering underlying cognitions (Harré, 1995). GT explores individual's accounts, with the aim of generating one over-arching theory, and was, in its original version, designed to investigate social processes from the bottom up, or the "emergence of theory from data" (Willig, 2008, pp. 44). An alternative perspective and additional understanding may be gained by adopting a phenomenological method, such as Interpretative Phenomenological Analysis (IPA), which aims to explore in detail how participants make sense of their personal and social world (Smith & Osborn, 2008). IPA shares some similarities with DA, in that it is a qualitative approach that places an emphasis on the importance of language. However, the two approaches differ in their epistemological positions and perception of the accessibility of cognitions (Smith, Flowers & Osborn, 1997). DA explores the role of language in a participant's descriptions of events, ascribing to a social constructionist epistemology, whilst the phenomenological approach examines how people ascribe meanings to their interactions with the environment (Smith et al., 2009), thus could be considered as nearer to a contextual constructionist position (Madill et al., 2000). Further discussion of these methods and the relevance to their epistemological positions will be presented in the methodology chapter.

A search of existing literature did not identify any published studies applying an IPA approach to explore help-seeking in male survivors of CSA. It was therefore considered, that the use of an IPA approach would enable the in-depth exploration of men's experiences of help-seeking, addressing the gap in the literature, and providing valuable insight from the voices of a hidden group, male survivors of sexual abuse.

Help-seeking covers a broad spectrum of activities, for example, social support, counselling, engagement with health professionals, the police, etc. For the purpose of the current study, help-seeking has not been defined; instead, this concept is to be explored by the ways in which males talked about seeking 'help' and the various forms they describe. The aim is to add to the current CSA literature, enabling further understanding of the context and meanings surrounding this phenomenon.

### Research Question

The research question to be explored is '***What are men's experiences of help-seeking as adult survivors of childhood sexual abuse?***' It is hoped that the findings from this research will provide an additional perspective on the existing literature and suggest directions for future qualitative and quantitative research. It is important to note that this research does not intend to discount women's experiences of CSA, as there is no doubt that such research has advanced our knowledge of sexual abuse in general; however, the focus for the current study concerns adult males as survivors of CSA.

This research is presented as part of the portfolio submitted to demonstrate competence for the Doctorate in Counselling Psychology. As such, this has influenced the design and implementation of the study, in particular, the area of focus, and epistemological stance.

## **Chapter 2: Design, Methodology and Procedures**

### **Outline of Chapter**

After taking the literature pertaining to male childhood sexual abuse into consideration, along with the aim and underlying principles embedded within this research, the focus now shifts to that of defining the framework within which the research is conducted. The following section discusses my rationale for using a qualitative research paradigm. Following this, qualitative methods will be discussed, and the process of arriving at the decision to use Interpretative Phenomenological Analysis (IPA) will be presented. This will be followed by followed by a section which explores my personal reflections. An outline of how the research study was carried out follows, including an explanation of the sampling, research procedure and ethical considerations. Finally, the analytic strategy used will be described.

### **Methodological and Philosophical Considerations**

Counselling Psychologists conducting research are urged to locate their research within a research paradigm which sets the context for the study (Ponterotto, 2005). Thus, the focus of this section of the chapter describes the process of considering how best to approach the research question: 'What are the experiences of help-seeking in adult male survivors of CSA?'

There are numerous ways in which this question could be investigated. Within different research paradigms, different epistemological positions can be taken (Madill, Jordan & Shirley, 2000); thus, it is important that researchers are explicit about their ontological beliefs and epistemological positions. Ontological questions are concerned with 'what there is to know' (Willig, 2008), whereas epistemology is concerned with the relationship between the inquirer and the known, and asks questions such as 'how can we know?' (Willig, 2001). These questions form the basis for the design and methodology of a study. Furthermore, a researcher's decisions about their research question and methods are primarily influenced by their epistemological position. With this in mind, it is important to consider the distinction between realist and relativist approaches. Realism and relativism represent two polarised perspectives on a continuum between objective reality at one end and multiple realities on the other. Adopting a realist position ignores the way in which the researcher constructs interpretations of the findings and assumes that what is reported is a true interpretation of a knowable and independent reality. Relativism leads to the conclusion that nothing can ever be known for definite, that multiple realities exist, none having precedence over the other in

terms of claims to represent the truth about social phenomena. Positivist researchers contend that there is one true reality, which can be identified and measured. Post-positivists also accept a true reality, but believe it can only be measured imperfectly (a position known as critical-realism). Constructivists (or social constructionists) propose that our knowledge of the world is not a direct perception of reality, and are concerned with how knowledge is constructed and understood. They place emphasis on everyday interactions between people and how they use language to construct their reality (Burr, (2003). Constructivists generally subscribe to a relativist ontology, in which multiple, equally valid realities are constructed amongst members of a society (Ponterotto, 2005).

Psychology generally has been dominated in the past by positivist and post-positivist research paradigms and associated quantitative methods of inquiry. Positivist epistemologies ascribe to the belief in a reality that can be identified and measured. A vast amount of the existing literature on the topic of CSA is largely quantitative, aiming to test hypotheses and find causal explanations. This provides valuable information; however, the focus for the current research is to look beyond hypothetico-deductive methods, which demand a focus on efforts to verify a hypothesis with the use of experimentation and statistical analysis (Ponterotto, 2005), to enable an exploration of the experiences of male survivors. Constructivist approaches, based on qualitative modes of inquiry, take a reflexive approach to the knowledge produced between the knower and the known. This epistemology emphasises the researcher-participant interaction, which is considered to facilitate and uncover deeper meanings (Ponterotto, 2005). Constructivists-interpretivists believe that multiple realities exist, and that reality is considered as subjective and influenced by the context of the situation, the social environment and the interaction between the individual and the researcher.

In terms of my ontological beliefs, I assume that a reality exists; however, I believe that participants will attach different meanings to their experiences as they will experience different parts of reality. CSA is never transparent in terms of what it means, either as an event itself or in the memory of it. It is something survivors 'make sense of' in the re-telling of such experiences. How we 'make sense' shifts according to the contexts in which we speak, with whom we speak with and what we speak about. CSA takes place in a socio-cultural setting (Hacking, 1995) wherein concepts such as 'truth' (about who is guilty or innocent and the aftermath of abuse) are subject to a wide range of interpretations. As stated, this is

dependent on who is doing the speaking, and the position he (or she) is speaking from. When participants share their experiences, this has an impact for them, and shares something about their thoughts, feelings and experiences, rather than the reality of the help-seeking experiences in male survivors. The author shares the conviction that participants' experiences are real and that CSA can give rise to distress both in the short and long term, yet what we experience as 'abuse' and talk about and the forms that our distress may take are constructed through language. The aim of the researcher is to ask questions concerning the nature of help-seeking after CSA, and explore how meaning is produced rather than simply represented in the ways we speak about it (Reavey & Warner, 2001).

My epistemological position can be described as 'contextual constructionist' (Madill et al., 2000). Willig (2008) states that 'contextual constructionist research is based on the assumption that all knowledge is contextual and stand-point dependant' (p. 153); therefore, different perspectives can give different insights into the same phenomenon. This fits well with the topic under research: how we theorise, recognise and talk about sexual abuse changes according to history, culture, law and social policy. It is assumed that those participating in the research, myself included, and the future readers of the study, will possess their own individual interpretation of the experience and reality regarding CSA (Creswell, 1998). Constructivists adhere to a relativist position that assumes multiple and equally valid realities exist (Schwandt, 1994). Reality is assumed to be constructed in the mind of the individual. This was particularly relevant in the current study, whereby men were invited to share their experiences. The experience itself was considered to be most important, rather than debating if such experiences are real or not.

The constructivist position espouses a hermeneutic approach, which maintains that meaning is hidden and must be uncovered by a process of interpretation (Pontorotto, 2005). As such, phenomenological methods, which aim to explore in-depth phenomena and uncover meanings with interpretation, were considered for use to explore the research question.

### **Rationale for using a Qualitative Research Paradigm**

Elliot, Fischer and Rennie (1999) propose that qualitative research aims to 'understand and represent the experiences and actions of people as they encounter, engage, and live through situations' (p. 216), whereas quantitative research aims to test hypothesised relationships or provide causal explanations (Elliot et al., 1999). Whilst quantitative research has been useful



in advancing knowledge on a variety of topics (for example, clusters of symptoms experienced by males (e.g. Bagley, Wood & Young, 1994; Hunter, 1991), qualitative methods allow for the emergence of unanticipated findings (Barker, Pistrang & Elliot, 2002) and have the potential to provide a richer understanding of the lived experiences of male survivors, which may not be sufficiently captured by quantitative research. Furthermore, the current study demands an idiographic focus of inquiry, which focuses on understanding the individual as a unique complex entity, rather than a nomothetic focus, which refers to people generally, or aims to produce universal patterns. In addition, the use of a qualitative methodology is well suited for topics for which there is little or no previous research or exploration when a phenomenon is not well understood (Cresswell, 1998), as is the case with male survivors of sexual abuse.

Qualitative approaches also fit well with the principles of Counselling Psychology. Counselling Psychologists have sought to expand methodological diversity, in particular, with regard to the use of qualitative research methods to adequately explore the depth and complexity of human experience (Morrow & Smith, 2000). When using a qualitative approach, each participant is empowered as he or she is viewed as being the expert in their own life and given a voice and an opportunity to share their experiences. According to Berg (as cited in Mudaly & Goddard, 2006), qualitative research allows participants to ‘...tell their own stories in their own voices, promotes new realities to be discovered by interactive dialogue between researchers and participants, and prevents the need to find simple answers to complex life issues’ (p. 66). This is particularly important when considering the target sample for this research, male survivors of CSA, a group who have been considered as neglected in the existing literature (Chouliara et al., 2012; Dube et al., 2005; Mendel, 1995) and are discouraged from speaking out about their experiences due to the stigma surrounding this topic (Alaggia, 2010; Lisak, 1994; 2005; O’Leary & Barber, 2008).

### **Choosing a Qualitative Research Method**

The umbrella term ‘qualitative stance’ shelters a diverse array of approaches and ideas, each with their own perspectives (Polkinghorne, 2005). Having decided that a qualitative approach was appropriate for my research question, I deliberated over which method to use. Grounded Theory, Discourse Analysis and Interpretative Phenomenological Analysis were considered. The following section of this chapter provides a brief overview of these methods.

### **Grounded Theory**

Grounded Theory, developed by two sociologists, Barney Glaser and Anselm Strauss (1967), has developed considerably since its introduction, and the differing backgrounds of the original authors must be taken into account. Strauss identified the depth and richness of qualitative research regarding social processes and the complexity of social life, whereas Glaser identified the systematic analysis inherent in quantitative research through line-by-line examination, followed by the generation of codes and categories (Hallberg, 2006, cited in Aldiabat & Navenec, 2011). Grounded Theory attempts to focus on process and change. The method assumes that social realities are negotiated by human actors and that a participant's interpretation of events shapes their consequences, thus subscribing to a symbolic interactionist perspective. Smith, Flowers and Larkin (2009) propose that Grounded Theory aims to generate a theoretical-level account of a phenomenon. For the purpose of the current study, it was considered important to explore each participant's experiences on their own merit. I felt strongly that each survivor's experience could provide a unique perspective and I wanted to capture this, rather than attempt to develop a generalisable theory of men's experiences of help-seeking.

A pre-requisite of Grounded Theory is to avoid exploring the research literature prior to analysis. At the time of conducting the research I had been volunteering for the National Association of People Abused in Childhood (NAPAC), who offer support to survivors of abuse. I therefore had knowledge of the literature, and an understanding of different experiences that survivors might encounter. I was also aware of the criticisms relating to Grounded Theory, in that it 'subscribes to a positivist epistemology and sidesteps questions of reflexivity' (Willig, 2008, p. 46). Perhaps one of the fundamental epistemological differences between these two approaches is that IPA says it is possible to know something about an individual's experience by careful analysis of their account of it and claims theoretical transferability (Smith et al., 2009), which refers to the presentation of knowledge which is consistent with the literature and has the potential to enhance theory and practice. Grounded Theory, however, assumes it is possible to create a grand theory which explains the phenomena being studied, and claims generalisability. In addition, for psychologists conducting research, Grounded Theory's original aim of exploring sociological research questions and its preoccupation with social processes has been said to limit its applicability to more phenomenological research questions (Willig, 2008).

### **Discourse Analysis**

Discourse Analysis (DA) was also considered. With its focus on language, DA is concerned with the action-orientated nature of language and explores how individuals use language to achieve social and interpersonal objectives (Willig, 2008). An example of a possible research question might be 'how do males speak about their experiences of CSA?' thus focusing on the language they use to describe such experiences. DA can take different forms; but, predominantly, 'discourse analysts are interested in the ways in which language constructs particular versions of experiences or events through people's accounts of them' (Willig, 2012, p. 38), rather than 'attempting to describe the authentic experiences and feelings of the participants' (Lupton & Chapman, 1995, p. 484). Willig outlines two versions of DA: discursive psychology (e.g. Edwards, 2004; Wiggins & Potter, 2008) and Foucauldian Discourse Analysis (e.g. Kendall & Wickham, 1999; Parker, 1992) and suggests that 'all varieties (of DA) share a conceptualisation of language as constructive and performative' (Willig, 2012, p. 38). DA (e.g. Potter & Weatherell, 1987) regards verbal data as behaviour in itself, and directs attention to the context in which discourse takes place. These approaches contain inherent difficulties for the present investigation, which aims to examine the experiences of help-seeking without discounting potentially key themes due to their frequency within the text. I therefore did not consider either method of Discourse Analysis appropriate as they involve exploring the function and power of language in particular contexts, which is not the focus of this current study. Although I agree that language is influenced by social processes, I do not believe it to be solely action-orientated and feel that we can make some inferences about people's experience based on what they say. Grounded Theory also differs from other methodologies with regards to its sampling of participants. Grounded Theory uses theoretical sampling; with the aim of gathering enough data until no new themes emerge, thus enabling Grounded Theory research to make generalisable claims about the broader population. This was not an aim for the current study. Having decided against the use of DA and GT, I considered using IPA, which provides a different perspective.

### **Interpretative Phenomenological Analysis**

IPA has been advanced by Smith and colleagues (e.g. Smith, Jarman & Osborn, 1999) as a qualitative method of data collection and analysis and which allows rigorous exploration of idiographic subjective experiences. Both the life worlds of participants and how meaning occurs and is made sense of in social interaction are considered important (Smith et al., 1999). IPA believes in a chain of connection between embodied experiences, talk about that

experience and a participant's making sense of, and emotional reaction to, that experience (Smith, 1996). Whilst IPA and DA are both linguistically based approaches, their rationale is different. IPA researchers talk to participants and analyse what they say in order to try and learn about how they are making sense of their experiences, whilst discourse analysts examine what participants say in order to learn about how they are constructing accounts of experience (Willig, 2008). It was important for me to choose a method that would enable an in-depth exploration into the individual and unique experiences of male survivors of sexual abuse, and the meanings they ascribed to these experiences. As such, IPA was considered a suitable method for exploring my research question.

### **Rationale for Choosing Interpretative Phenomenological Analysis**

IPA has historically been used in the field of health psychology; however, its broad application has been demonstrated across Clinical and Counselling Psychology (Eatough & Smith, 2008). In addition, a large body of research documents the utility of IPA in researching under-researched areas (Smith, 2004), and it is now a widely used method within psychology (Smith et al., 2009). The efficacy of an IPA approach has been illustrated with survivors of CSA in a study by Phanichrat and Townsend (2010). De Visser and Smith (2006) have also demonstrated the use of IPA with men, in a study exploring the links between masculinity and men's health behaviour. IPA aims to give voice to, and examine in detail, the personal lived experience of participants and how they make sense of their experiences (Smith, 2004), and is an ideographic approach, concerned with a focus on the particular rather than the universal. It does not aim to find causal explanations for events or produce objective 'facts' (Smith & Osborn, 2008) as is the case with Grounded Theory. I considered that IPA would enable me to investigate men's experiences of help-seeking and the meanings they ascribed to this experience. In addition to this reason for using IPA, I had also attended a workshop on the practical application of IPA, and was interested in the flexibility this method offered.

### **The Philosophical Underpinnings of Interpretative Phenomenological Analysis**

Smith et al. (2009) describe IPA as 'an approach to qualitative, experiential and psychological research, informed by concepts and debates from three key areas of the philosophy of knowledge: phenomenology, hermeneutics and ideography' (p. 11). IPA draws on these areas to inform its distinctive epistemological framework and research methodology. This relationship is discussed in a number of papers (e.g. Smith, 2004; 2007; Larkin, Watts & Clifton, 2006) and will be discussed further below.

### ***Phenomenology***

Phenomenology has been defined by Langdrige (2007) as 'the study of human experience and the way in which things are perceived as they appear to consciousness' (p. 10). IPA assumes that participants are experts on their own experiences and can offer researchers an understanding of their thoughts and feelings through telling their own stories, in their own words, in as much detail as possible. This facilitates the development of text that described the 'lived experience' of a phenomenon and one's attempts to make sense of their experiences. In addition to the phenomenological focus, the influence of Heidegger's hermeneutic phenomenology on the development of IPA is seen through the emphasis placed on interpretation and the role of both participant and researcher in a dynamic research process.

### ***Hermeneutics***

Hermeneutics focuses primarily on the meaning and interpretation of qualitative data. Its purpose is to aid understanding by helping the researcher to understand what people say and do, and why. Smith (2007) emphasises the importance of the hermeneutic circle, which refers to the dialectic between the understanding of texts as a whole, and the interpretation of its parts. Human understanding is achieved by iterating between the parts and the whole which they form. IPA acknowledges that an individual's experience cannot be accessed directly; however, it guides the researcher to examine the experiential reality and understand an experience by investigating how it is experienced and given meaning by the individual (Eatough & Smith, 2008; Smith, 1996). Smith refers to 'double hermeneutics' (Smith, 2004, p. 40), the process by which the participant is trying to make sense of their personal and social world whilst the researcher is trying to make sense of the participant trying to make sense of their personal and social world. Access to this world is 'both dependant on, and complicated by the researchers own conceptions, which are required in order to make sense of that other personal world through a process of interpretative activity' (Smith, 1996, p. 264).

### ***Ideography***

Ideography is concerned with the particular, the distinct experiences of particular individuals and the particular contexts in which those experiences occur (Eatough & Smith, 2008; Smith et al., 2009). IPA is considered idiographic as it is concerned with the particular and involves a detailed examination of an individual's personal experiences or perception of an account

(Smith, Flowers & Larkin, 2009). The commitment to ideography is evidenced in the writing-up of single case studies, which represent the in-depth examinations of the lived experience of a single person (e.g. de Visser & Smith, 2006). More commonly, IPA involves the detailed examination of each case, followed by the search for patterns across cases. Rather than seeking to generalise, IPA is concerned with the convergence and divergence within the sample, presenting both the shared themes, and illustrating the particular ways in which these themes play out for individuals (Smith, 2011). For the purposes of this study, the idiographic nature of IPA might be considered an advantage: it allows the analysis to focus on the particular experience of participants. Given the absence of previous research in this area, it provides a constructive way to expand knowledge and evidence around this topic.

IPA is influenced by 'Symbolic Interactionism' (Denzin & Lincoln, 2000), with its curiosity for how meanings are constructed by individuals within both their social and personal world (Smith, Flowers & Larkin, 2009), and is primarily concerned with how the participant experiences the world, rather than the truth of reality, which makes sense when considering how adult survivors of CSA reflect on their past traumas. The objective of the analysis is to, through their account, obtain an insight into another person's thoughts and beliefs about a phenomenon. However, the IPA methodology takes the position that such experience is never directly accessible to the researcher. As a result, the 'phenomenological analysis is always an interpretation of the participant's experience' (Willig, 2008, p. 57). The knowledge produced by it is, therefore, also reflexive in so far as it acknowledges its dependence on the researcher's own standpoint (Willig, 2008).

IPA aims to conduct an examination of data in a way that enables the participants' experiences to be expressed in their own terms (Smith et al., 2009) and makes inferences cautiously and with an awareness of the contextual and cultural ground. This study aims to reveal participants' attempts at help-seeking and to transparently demonstrate the interpreted meanings ascribed to those experiences. The researcher will remain aware of any assumptions brought to the analysis and ensure that these remain consistent with qualitative research: that reality is subjective with multiple versions of reality existing (Creswell, 2007). Considering this, it is important to remain critical and reflective throughout the research process. IPA recognises that a researcher's understanding of thoughts is necessarily influenced by his or her own ways of thinking. However, these are not seen as

biases to be eliminated, instead they are considered to be a necessary precondition for making sense of another person's perspective.

### **IPA as a Method**

In IPA, analysis is inductive in nature, allowing ideas and themes to emerge from the personal accounts, rather than imposing a predetermined theory, thus opening up the researcher to possibilities that had not been considered. The approach adopts both emic (insider) and etic (interpretative, outsider) positions (Reid et al., 2005). The emic position enables the researcher to hear and understand the participant's story and place his or her experiences at the centre of the account. Adopting the etic position involves the researcher trying to make sense of the data by bringing in his or her own interpretations and theoretical ideas, but using verbatim quotes to ground these interpretations in the participant's actual experience. Reflexivity, therefore, is an important and central part of IPA in ensuring that the researcher remains aware of how his or her personal experiences and pre-understandings are influencing data analysis (Finlay, 2008).

### **Criticisms of IPA**

Criticisms of IPA have been raised, and it is acknowledged that each method has its own strengths and weaknesses. In their review of the IPA literature, Brocki and Wearden (2006) highlight how a lack of guidance about how much the researcher should interact with the participant, or start to interpret data within the interview, has led to variations in the amount, quality and depth of information provided. Concerns have also been raised by Willig (2008), who infers that IPA is unable to provide causal explanations of a particular phenomenon; however, it is argued that this is not the focus of qualitative research and that IPA is one way of contributing to the knowledge about a phenomenon, rather than providing a causal explanation. Another debate concerns cognition, and IPA's use of this term, and if, in fact, the study of cognitions can be phenomenological (Langdrigde, 2007; Willig, 2008). Eatough and Smith (2008), however, respond to this regarding their conceptualisation of the term, disputing the widely accepted idea that cognitions can only be conceptualised as isolated and discrete processes managing sensory input, as they are considered in cognitive psychology. Instead, it is argued that cognitions are an aspect of being-in-the-world and therefore cognition is construed as an attempt at meaning-making, an aspect of lived experience central to human existence (Eatough & Smith, 2008).

## **IPA and its relevance to Counselling Psychology**

IPA has developed from a broad range of theoretical influences and therefore does not claim a distinctive epistemological position, but rather described itself as 'a set of closely connected approaches which share a commitment to the exploration of personal lived experience' (Smith, 2004, p. 41). Within this there are different interpretative stances available to the researcher. Bor and Watts (2011) suggest that researchers should use a methodology that is consistent with their counselling approach. The Division of Counselling Psychology state that Counselling Psychologists seek to 'engage with subjectivity, values and feelings...to know empathetically and respect first person accounts as valid in their own terms' (BPS, 2005, p. 1). With this in mind, I reflected on my role as both a CP who has worked with survivors, and a researcher interested in learning more about individuals' experiences. I view the therapeutic relationship as central and each client as an individual. Thus, my counselling approach appears consistent with an IPA perspective which states that participants are the experts on their own subjective experiences and participants' perceptions of these experiences (Reid, Flowers & Larkin, 2005). IPA assumes a chain of connection between how people talk about their experiences, their thinking and emotional state. At the same time, those using IPA realise that this chain of connection is complicated, and that people sometimes struggle to express what they are thinking and feeling (Smith & Osborn, 2008). This is particularly relevant to male survivors of CSA who may have struggled with silence and keeping quiet; therefore, the researcher plays a role in the interpretation of such data.

An advantage of IPA is that it offers and encourages flexibility in adapting the method to suit the researcher's way of working and the particular topic of investigation (Smith & Osborn, 2008). In addition, IPA complements the ethos and values of Counselling Psychology, highlighting the importance of subjective and intersubjective experiences and meanings, along with the empathic engagement of the psychologist with the world of the client. Counselling Psychologists are encouraged to accept and respect the subjective accounts of the client as meaningful and valid in their own terms, and see the individual uniqueness and complexity of each individual by engagement and interaction at many levels. In its definition of Counselling Psychology found in the Professional Practice Guidelines (British Psychological Society, 2000), the Division of Counselling Psychology emphasise a number of aspects parallel to the principles of IPA. Thus, there exist parallels between the Division's definition and the aims and objectives of IPA, which seeks to understand and give voice to the participant's



concerns, make sense of a participant's account and contextualise it from a psychological perspective (Larkin, Watts & Clifton, 2006).

Counselling Psychologists adopt a reflective stance and hold a humanistic value base and are focused on understanding the subjective world of the self and other (Strawbridge & Woolfe, 2010). By using IPA it is possible for Counselling Psychologists and other professionals who come into contact with male survivors to develop a deeper understanding of the experiences of clients, which in turn may facilitate reflection on current practices and lead to changes that enhance service provision or lead to further research. IPA was chosen on the basis of its distinct focus on lived experience and sense-making, and for its potential to enhance existing literature by using IPA with a male sample of CSA survivors.

## **Procedures**

### **Sampling and Participants**

With the idiographic emphasis of IPA, the aim of a study is not to generate large quantities of information but to gather quality information that will enable a deeper understanding of the participants' experiences to emerge. IPA sampling tends to be purposive and broadly homogenous, as a small sample size can provide a sufficient perspective, given adequate contextualisation (Smith & Osborn, 2003).

Smith et al. (2009) state that participants 'represent a perspective, rather than a population' (p. 49), and given the trend for increasingly smaller sample sizes in IPA studies, including single-case investigations (e.g. de Vissar & Smith, 2006; Eatough & Smith, 2006), the current sample size of seven was considered acceptable and in line with the idiographic focus of IPA. Although there is no prescribed number of participants suggested, as a general rule, Smith et al. (2009) recommend using between four and ten participants for a Professional Doctorate study using IPA. Samples should also be as homogeneous as possible to allow the researcher to explore a phenomenon as it is shared by a specific group (Smith & Osborn, 2008). A homogenous sample can be considered as a closely defined group, for whom the research question will be significant. In the current study, the target sample was adult male survivors of sexual abuse (exclusion and inclusion criteria for the study are defined below). In order to ensure a fairly homogenous sample, purposive sampling (Morrow, 2007) was used. This allows for selection of participants on the basis of their ability to provide the researcher with

an understanding of the phenomenon being studied (Polkinghorne, 2005). The difficulties inherent in accessing participants involving sensitive research topics are well recognised (Renzetti & Lee, 1993) and, inevitably, sampling invisible populations is a research issue with abuse survivors. Abuse has often been kept a secret and survivors may therefore be unwilling or unlikely to participate in research; thus, in order to obtain participants it was necessary to simplify inclusion criteria, rather than, for example, specifying particular factors, such as length or frequency of abuse, or geographical location. Although anticipated, difficulties in accessing participants did not materialise. Nevertheless, the desired sample constituted a 'difficult to reach population' (Neuman, 1997).

Inclusion criteria stipulated that participants must be over 18 years old, of any nationality, race or sexual orientation, and identified themselves as having experienced sexual abuse in their childhood (before age 16). Sexual abuse was not predefined; however, if participants were unsure as to whether their experiences constituted sexual abuse, the definition below, as outlined by the Department of Health, was made available. This states that:

*Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities including prostitution, whether or not the child is aware of what is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities, or encouraging children to behave in sexually inappropriate ways'* (Department of Health: Working Together to Safeguard Children: DfES, 2006).

In the early stages of this project I considered defining CSA as I am aware that many survivors have difficulty defining what happened to them as abuse; however, due to previous methodological issues with definitions, I considered that this would be futile.

Participants were required to have the ability to give informed consent to participate, and be willing to participate following a description of the study. Male survivors who were waiting to provide evidence in court due to their sexual trauma, and anybody experiencing major mental health issues (e.g. actively psychotic or actively suicidal), were excluded from taking part as the content of the interviews may have caused them further undue distress. Given

the highly sensitive and personal nature of the subject matter, as well as related social representations and stereotypes about childhood sexual abuse, demographic information collected in this study was kept to a minimum. This was a pragmatic choice in order to minimise intrusion and ensure acceptability of the study by participants as far as possible.

From reviewing the literature I was aware of the difficulties that have been encountered in previous research with regard to recruiting male participants; therefore, I contacted a number of organisations prior to beginning the research, and arranged to attend a number of workshops for survivors of CSA where I had the opportunity to introduce my research and distribute information flyers (see Appendix A). I also put information about my study on the NAPAC website and sent out information via their volunteer co-ordinator. Research flyers were emailed to London-based online support sites to recruit possible participants. I advertised for prospective participants on groups set up on Facebook including 'NAPAC', 'Adult Survivors of Childhood Sexual Abuse', '(Wo)Men Speak Out' and 'Boys and Men Healing' with the permission of the groups' administrators. I also placed the link to my research flyer on a Twitter page used solely for research purposes, and set up a research page with information regarding the study with an anonymous link which notified me of interested participants. I used a range of communication methods to target a wide audience. Previous research by Woodward and Joseph (2003) used NAPAC to recruit participants and a total of seventeen men took part and more expressed an interest in the study. Phanichrat and Townshed (2010), exploring coping after CSA, also used online support services to recruit potential participants.

Initially, ten males made contact to inquire about the study; three were based in America and made contact due to seeing the advertisement on a social networking site. These individuals were informed that recruitment was limited to the United Kingdom, but were sent information detailing CSA support links in America. Following the current media increase relating to the accusation of a number of celebrities perpetrating CSA, a further three participants contacted me in October and November 2012. Recruitment had ended, so they were unable to be included in the study, but were also given information regarding support networks. The remaining seven participants met the criteria for inclusion in the study. The age of these participants ranged from 30–55 years old. All participants were male, and shared the experience of having been sexually abused in childhood. As such, the sample can be considered as relatively homogenous.

Brief details of the participants who took part in the study are shown below. Names and demographic details have been changed to protect participants' anonymity. All of the males were white, aged between 30 and 65 years of age and UK residents. As stated in the method section, minimal demographic data were collected to ensure participants felt as comfortable as possible in taking part and to minimise unnecessary intrusion.

- Dave** Dave is in his fifties; he was sexually abused as a child by a male family member and did not seek help until adulthood.
- Ben** Ben is in his mid-thirties; he was sexually abused as a child by a male family member and his brother's female partner. He sought help in his late twenties.
- Dan** Dan is in his late forties. He was sexually abused by a stranger before the age of five and again later at boarding school. He first attempted to seek help in his late teens and again in his mid-thirties.
- Sam** Sam is in his fifties. He was sexually abused by a family member. He has never sought help directly but has found writing a book about his experience as helpful in his recovery journey.
- Jack** Jack is in his early forties. He was sexually abused as a child at boarding school and did not seek help until his mid-twenties.
- Joe** Joe is in his mid-fifties. He was sexually abused as a child at boarding school. He kept his abuse quiet and sought help in his thirties.
- Barry** Barry is in his forties. He was sexually abused as a child whilst at boarding school by both male pupils and teachers. He sought help after experiencing an emotional break-down in his thirties.

Each participant was contacted individually prior to the commencement of the study in order to discuss the requirements of the research and to answer any questions they had. The aims and purpose of the study were explained and written consent was sought prior to taking part in the interviews. Potential participants were given pseudonyms, which were used throughout to protect their anonymity. Those interviewed were self-selecting, defined themselves as survivors of CSA and included those who had not previously disclosed CSA, and those with previous experience of help-seeking. Participants considered themselves to be psychologically able to take part and understood the nature and reasons for the research.

## **Procedure and Ethical Considerations**

Data were collected via semi-structured interviews, the 'exemplary method' for data collection in IPA (Smith & Osborn, 2008). Willig (2001) suggests that this method allows the interviewees to discuss in detail and in their own words particular aspects of their lives and experiences. Eatough and Smith (2006) highlight how semi-structured interviews allow a flexible approach to data-gathering for IPA and give a central place to understanding the individual's experiences and meanings whilst maintaining an awareness of the contextual factors surrounding the interview.

The possibility of working with potentially vulnerable survivors of CSA emphasised the fundamental importance of maintaining an ethical framework to ensure that both the participants and the researcher were protected from harm. As such, the study was conducted in accordance with the ethical standards of the British Psychological Society (BPS, 2009). These standards require that participants give informed consent, are allowed to withdraw at any stage, are assured of confidentiality and anonymity, and protected from any physical or psychological harm or distress. The researcher was also ethically obliged to inform the participants that there would be no monetary compensation arrangements for taking part in the research. Ethical approval was also granted by City University (see ethics release form at Appendix J).

Participants were provided with an information sheet prior to consenting to take part in the study. A short introduction and discussion enabled the researcher to check if this had been read and if there were any questions. Consent was checked again prior to beginning the interviews. Participants were invited to begin with a brief background, which enabled the researcher to gain a perspective within which to base further questions. This also served to encourage the participant to speak freely about their experiences without a specific agenda on the topic of help-seeking. The interviewer's primary objective was to establish a rapport with the participants, with the aim of ensuring that the participant talked freely about the issues which were pertinent to them. One-to-one interviewing gives researchers the ability to 'give voice to survivors' (Reinharz & Chase, 2002). Participants were encouraged to share their stories in their own words without the restrictions of specific questions or closed-ended response categories, enabling the researcher to gain a more valid understanding of the topic than what could have been achieved through a more rigid approach (Carr, 1994; Duffy, 1986). The interviewing style was flexible, with interviews lasting between 60 and 90 minutes. The

researcher followed principles of sensitive interviewing (Chouliara, Kearney, Worth & Stott, 2004). If at any time participants demonstrated signs of distress, the option of ending the interview or taking a break was offered. In order to make the process as comfortable as possible, interviews were conducted at safe locations, including at City University. Measures were taken to ensure both the safety of the participants and the researcher. Where the interviews were held outside of City University, the researcher informed two colleagues of her whereabouts and anticipated ending times.

Two interviews were conducted via Skype to enable participation from those living too far to travel to London. Skype is a form of online software which enables users to communicate by voice, video and instant messaging over the Internet. In recent years, the Internet has emerged to become a popular method of communication due to its increasing ease of use, decreasing cost and ability to communicate with others across large distances ((Hanna, 2012; Joinson, 2003). The use of the Internet as a social support and interpersonal tool has arisen for several reasons. Online support-seeking provides anonymity and reduces social stigma, giving individuals a place to explore their experiences, concerns and questions with a sense of personal safety. Using Skype gave participants a degree of control over the research process (Hanna, 2012) and enabled those who did not wish to travel or meet in person to take part. In addition, considering the sensitive nature of the topic, it enabled participants to take part in their own home. Furthermore, the practical benefits of scheduling the interview at times to suit both the participant and the researcher were also considered an advantage. Skype also enables visual aspects of interacting (Evans, Elford & Wiggins, 2008) without imposing on another's personal space. This enabled the researcher to use non-verbal communication to offer support or encouragement (e.g. nodding, facial expressions) and also enabled the identification of any signs of discomfort or distress when carrying out the interviews. Recent research suggests that due to the lack of services for male survivors, many males are turning to Internet support groups as a form of help-seeking (Craig, 2010; Foster, 2011). In his research exploring the use of the Internet as a support medium, Craig (2010) found that male survivors considered the visual aspect of seeing another person to be an important factor in developing relationships (Craig, 2010).

The exclusion criteria were outlined in the information leaflet, and were discussed again prior to beginning the interview with particular reference to risk. Participants were asked about their social and psychological support networks, and I clarified that they had support in place

or options to access support, should taking part lead to them experiencing any distress. In addition, participants were provided with a leaflet which provided details of organisations that could provide support following the interviews if required. Participants who wished to take part signed a consent form (Appendix C), and were informed that interviews would be audio-recorded and data stored on an encrypted memory stick, and on a password-protected computer for the duration of the project. Participants' interview recordings will then be deleted following completion of the research study.

Interviews began with the researcher introducing herself and the research. In light of the topic under investigation, the researcher had considered the ways in which to commence the interview and data collection, bearing in mind that participants may be anxious about sharing their experiences. CSA is often characterised by secrecy, isolation and the silencing of its victims; this in itself has implications for how such a phenomenon should be explored and thus might impact on a participant's ability to recount their experiences (Durham, 2003). Participants were informed that they did not have to discuss the experience of the sexual abuse itself, but rather their experience of help-seeking following this experience and in adulthood, and advised that they did not have to answer any questions they found uncomfortable or distressing. Each participant took part in one interview lasting approximately 60-90 minutes. Interview times were flexible to allow participants time to share their experiences. In designing the interview schedule, the researcher was mindful of the areas and topics that might arise in relation to the research question, yet also wanted to allow space for the participants' personal reflections. Questions were designed to be open-ended and non-directive in accordance with IPA principles (Smith & Osborn, 2008). The interview schedule can be found at Appendix D.

The study involved no physical risk to participants beyond what they may encounter in daily life; however, it is possible that talking about past traumatic events such as childhood sexual abuse could be emotive and potentially distressing. With this in mind, particular attention was paid to following ethical procedures to ensure that participants were comfortable with taking part, had some support in place and were followed up after taking part to check for distress. In any undertaking of research, care of participants is extremely important. Most practitioners will be sensitive to any distress likely to be caused in a study and will take steps to address this. Coyle and Wright (1996) suggest using counselling techniques such as active listening and empathy in qualitative research on sensitive topics. At all times, the researcher

was aware of the sensitive nature of the interview and McLeod's (1994) assertion that interviews can re-stimulate painful memories or unresolved emotional conflicts. Participants were informed they could stop the interview at any time to take a break, which two participants did. Both were happy to resume the interview afterwards.

Information detailing support networks was provided to participants at the end of each interview, along with the contact details of the researcher. Participants were informed that these details could also be used in the event that they had any questions or concerns about the research prior to or after the interviews, or if they wished to withdraw from the study at any stage up to three months before submission. Information sheets with local support groups and available support resources were also provided. The researcher informed participants that excerpts of interviews would be shared with their supervisor and used for the final analysis section of the research; however, it was made explicit that any identifying information would be removed and any excerpts used would remain completely anonymous. It was also considered important to re-visit consent before and after collecting data (Rosenblatt, 1995), and offering to delete from the transcript anything the participant regretted saying or would prefer not to be divulged further. Only one participant asked for a section of the transcript to be deleted and his request was carried out. These measures facilitated the establishment of rapport between researcher and participants.

### **Post Interview**

After each interview, participants were debriefed and asked several questions about their experience of the interview process to ascertain any potential distress caused by taking part. One participant mentioned not having spoken about his experiences to anyone other than immediate family, and talked of his partaking as being an important stage in his recovery journey. Others mentioned gaining new insights into their thoughts and feelings and reflected on their own courage and strength. Participants were informed that their emotions might be heightened after sharing their abuse experiences, which is normal after sharing difficult or traumatic experiences. Whilst some participants stated they found the interview an emotional experience, none reported feeling or appeared distressed. Participants were asked if they felt they needed any additional support and were informed that they could contact NAPAC for telephone support if they wished to discuss anything related to the interview, or any emotions that had resurfaced as a result of taking part. Understandably, when talking about their experiences, negative emotions may have resurfaced and care was



taken to close interviews accordingly. Participants were informed that they would receive an email the following week to enquire about their thoughts and feelings post-interview, which would give them an opportunity to discuss any concerns that could be addressed by the researcher. Etherington (2004) writes about the importance of researcher self-care and reflexivity. Following each interview, reflexive notes were written, detailing the researcher's initial thoughts and feelings, as recommended by Brocki and Wearden (2006), providing useful material for discussion in research supervision. In preparation for conducting the analysis each interview was transcribed by the researcher into a word document. Line numbers were added to the text and space left on the left and right margins for analysis notes and themes. The transcribed interviews were stored on a password-protected computer and an encrypted memory stick.

### **Analytic Strategy**

Each transcript was analysed separately using IPA, and was guided by two aims: 1) to understand and represent the experiences of the participants as closely as possible; and 2) to interpret this understanding within the wider context of a particular situation (Larkin et al., 2006). Guidelines for analysis described in detail in Smith and Osborn (2008) and Smith et al. (2009) were used to facilitate analysis. The first stage involved reading and re-reading each first transcript, and listening to the audio recording. This evoked thoughts and memories of the interviews which were noted in one margin (an example of this can be seen in Appendix F). Eatough and Smith (2008) advocate the adoption of two levels of interpretation. The first, a more descriptive, empathic level, aims to allow the researcher to enter the participant's world, whereas the second critically interrogates the participant's account in order to gain further insight into its nature and meaning, thus taking the researcher beyond the participant's own words and understanding(s) (Willig, 2008). Reading and listening to the interviews enabled immersion in the data to facilitate in-depth analysis. The second stage of analysis involved re-reading the initial text and notes and noting the emergence of themes that captured individual parts of the transcript. Particular attention was paid to the areas of most significance for the participant (Larkin et al., 2006). These were identified by either the content of the transcript, or from my initial notes about the interview, for example, the experience of disclosure for one particular participant. In IPA it is assumed that a participant's account in an interview represents an attempt to make sense of their personal and social world (Larkin et al., 2006). However, it is acknowledged that the participant's account is unavoidably filtered through the researcher's own beliefs, attitudes and experiences (Smith,

1996). Consequently, analysis involves a 'double hermeneutic' (Smith, 2004), whereby the researcher's interpretations form an attempt to make sense of the participant making sense of their experiences. Considering this, I made descriptive notes about my own thoughts and sense-making and shared these with my supervisor to ensure my initial ideas about themes were relevant to the data.

When all emergent themes were identified from a transcript, these were typed into a list as suggested by Smith et al. (2009). Recurrent themes were then identified across transcripts, and links between these themes established. Repetitions of the emergent themes across individual transcripts were taken as indicative of their status as recurrent themes, reflecting a shared understanding by participants of the issues under investigation. This process was repeated for each of the transcripts. Care was taken to treat each interview on its own merit, and bracket ideas emerging from previous interviews. Once emergent master themes were clustered and the sub-themes named, a theme table was produced. Page numbers and occurrence of the emergent themes, as well as a key quotation, were inserted into the table to show that the themes were supported by the text. All participants were given a pseudonym to allow direct quotes to be used anonymously. Analysis in IPA is an iterative process that involves repeated immersion in the text to confirm that the emergent themes and interpretations are supported by the data (Smith, Jarman & Osborn, 1999). The analysis process is not a discrete stage of the research, but rather continues throughout, allowing new themes to emerge even during the write-up phase; as such, several themes were later re-labelled and reconfigured to form master themes consisting of constituent themes. The themes were then translated into a narrative and have been represented in the following chapter (Analysis - Chapter 3).

### **Reflexivity**

In order to enhance the credibility of their findings, researchers must account for their values, beliefs, knowledge and biases, and make explicit the perspectives from which they approached the design of the study, the data collected, demonstrating reflexivity regarding their impact on the research process (Willig 2008). With this in mind, I will share a little about my own preconceptions and discuss how these may have an influence on the research. I will also consider the ways in which I will contain these biases so as not to overshadow my participants' accounts. I am a white British female in my early thirties, and although I do not have personal experience of sexual abuse, I grew up in an environment where talking about

sex was a taboo subject. Society has changed dramatically over the past two decades and it has become more acceptable to talk openly about sexual practices and sexuality; however, the topic of sexual abuse still appears to be an uncomfortable one. After studying 'violent relationships' during my Masters, I became interested in the subject of sexual violence and the impact on survivors. After my first experience of working with a client who had suffered CSA in his teens, I realised that I wanted to understand and learn about the experiences of male survivors of CSA. I learnt a lot from my work with this client and feel this was an extremely valuable case in my professional development. As my clinical placements continued, I encountered other adults with similar difficulties to those experienced by my first client, who had also never spoken about their past traumas involving sexual abuse. I enrolled on a course to help further my learning in supporting survivors, and raised the topic with colleagues and supervisors, enquiring about their experiences of working with this population. I sensed some reluctance towards the topic area and was even told by one health professional to choose a more straight-forward area to research. This only served to fuel my interest further and I searched for information and literature to enhance my understanding. I became frustrated at the lack of support for male survivors and also became passionate about investing my time to help this under-represented group.

Willig (2008) emphasises that a researcher's preconceptions about the world are not biases to be removed, but are a necessary precondition for making sense of another person's experiences and, as such, must be reflected on. Maintaining awareness of my assumptions was therefore a crucial component of producing authentic results (Polkinghorne, 2005). The way I perceive, interpret and experience the world provides a lens through which I examine all incoming information. As a result, I do not believe that it is possible to fully set aside my own assumptions, and I believe there is value in outlining these at the onset of a study. Identifying and acknowledging such things provides a measure of accountability when examining the interpretations and reflections from the data. Further, acknowledgment provides a level of transparency with readers of the study. The process of outlining my own assumptions and biases in the form of keeping a journal at the onset of the study, revisiting them and continuing to journal throughout the course of the research process assisted me in maintaining focus on the participants' experiences. My aim was to bracket my own thoughts and, as far as possible, engage with the data and emergence of themes in a fresh and open manner (Finlay, 2008). It is hoped that my continued reflexive process throughout the subsequent chapters will provide insights into the subjective and inter-subjective factors that

have influenced the research, therefore increasing its integrity and trustworthiness. Journaling enabled my personal reflections and questions to be noted for later discussion in research supervision. It is possible that my desire to study this topic may have directed my research questions and the interpretation of my data and, as such, caused me to focus on aspects of participants' accounts consistent with what I wish to portray. However, I have always remained aware of my assumptions and entered each interview and subsequent analysis with a new curiosity about what I might find out, putting my own views aside and being open to new experiences. My personal reflections can be found in the 'Personal Reflexivity' section of the Discussion (Chapter 4).

I believe that knowledge is contextual, which concurs with Larkin et al. (2006), and that discoveries made in this research study will be dependent on the relationship that I have with my participants. Smith and Osborn (2008) refer to a 'double hermeneutic', in which the researcher attempts to make meaning of the meaning derived by participants. An interview is an interaction between two people; therefore, it is inevitable that I may have influenced the accounts of my participants. My listening and attending became an integral component, impacting participants' responses (Polkinghorne, 2005). It is probable that someone else conducting a similar study may well have come up with different findings, as participants may have discussed different aspects of their experiences. Similarly, another researcher may have focused on different aspects of participants' experiences during the analysis stage. This belief is consistent with IPA, which as Smith (1996) notes, has its roots in symbolic interactionism, which Holstein and Gubrium (2000) describe as 'the principal that individuals respond to the meanings they construct as they interact with each other' (p. 32). With this in mind, it is also important to reflect on the structure of the interviews, any contact with the participants, and how these factors may impact on what information is shared. It is important to note that the interpretations of the participants were accessed within a specific context and at a certain time. Therefore, it is possible that the meanings and interpretations made by my participants may not be reflective of their experiences at another time in their life (Larkin et al., 2006). Similarly, the interpretations and meanings I ascribed to the interview data were also generated within a specific context and time; as such, it is possible that they may not hold over the course of my lifetime. Despite this, it was felt that using one-off interviews would enable an insight in to the life-worlds of participants at this time, with the aim of revealing valuable information about men's experiences.

Smith et al. (2009) suggest that it is important to be able to relate to or imagine the experiences and concerns of one's participants. I feel that my experience as a telephone support volunteer at NAPAC offered me an insight in to the difficulties faced by survivors. I was aware that many male survivors are sceptical about seeking support. This made me wonder if I would be able to successfully recruit participants. Prior to conducting the research I attended a conference for survivors and noted that there were several males in attendance. During the conference, they voiced concerns about health practitioners not knowing 'where to send them' and their need to be reassured that someone could understand what they were going through. Several of the males described feeling misunderstood by health professionals.

Fontana and Frey (2003) state that the way a researcher presents themselves is important, as this can influence the success or failure of a research study. I felt it important for participants to know that whilst I was by no means an expert, I have had some experience of working with and supporting survivors of CSA. With this in mind, I shared that I had been a volunteer at NAPAC in my recruitment material, as I wanted my participants to feel assured that I had some awareness of the issues that survivors may have encountered. I also made it explicit that questions would not be asked about the details of the sexual abuse, but instead about the process of help-seeking as an adult male. I ensured that all aspects of the research study were collaborative and participant-led, therefore addressing any potential power imbalance that may have arisen from me being a female health professional. Further discussion about this can be found in the 'Procedure and Ethical Considerations' section of this chapter.

## Chapter 3: Analysis

### Outline of Chapter

The following chapter describes the master themes and sub-themes derived from the analysis of seven interview transcripts. The themes presented are the result of a unique interaction between the researcher and the data. In telling their stories, participants shared detailed accounts of their lives, the challenges and dilemmas they faced, and the complexities of help-seeking, enabling an in-depth phenomenological insight into the experiences they encountered. One of the aims of this chapter is to allow participants' voices to be heard. It was therefore important for both the quotes selected and the commentary to reflect the participants' own experiences and how these emerged in the context of the interview. Despite the use of open-ended questions, participants weaved their stories between the questions posed providing a chronological account of their experiences synonymous with the concept of a journey through their lives. The themes have therefore been presented to illustrate this, starting at the beginning, with themes associated with life pre-disclosure, before moving on to the disclosure process and subsequent experiences of seeking help.

### Overview of Themes

Analysis of the data using IPA led to the emergence of four master themes. These are presented below.

**Table 1: Themes and Master Themes**

Master Theme	Sub-Theme
1. Disclosure	1.1 Pre-disclosure (Dissociation, Detaching and Distancing)
	1.2 Secrets and Silence
	1.3 Experiences of Telling
	1.4 The Freedom of Disclosure
2. Searching	2.1 It's Like a Desert Out There
	2.2 Being Male and Searching for Help
3. The Help-Seeking Journey	3.1 Relationships (Developing, Managing and Negotiating)
	3.2 Hindering Aspects
	3.3 Helpful Aspects
4. Continuing the Journey - Making Sense and Moving Forwards	4.1 Making Sense of the Past
	4.2 Recovery as an On-Going Process

It is important to note that although the master themes have been presented as distinct, there is overlap between and within them. Additionally, whilst each master theme was in some way representative of all of the participants in the study, not all of the sub-themes represented each individual. The data gathered was extensive and the scope of this work does not allow for an exhaustive presentation of the findings; however, relevant quotes have been selected to illustrate key themes that emerged from the data. As Osborne and Smith propose, the material presented in this chapter offers the reader ‘a co-construction between participant and analyst’ (1998, p. 67). In order to present the data with the greatest clarity and fluidity, and to represent as closely as possible the way the data has emerged for the researcher, further discussion of the data with relevance to psychological theory and concepts and in relation to the existing literature will follow in the ‘Discussion’ section of this work (see Chapter 4). Additionally, any implications for clinical practice within the remit of Counselling Psychology that are established from the data analysis will also be explored in the ‘Discussion’ section.

The first master theme ‘Disclosure’ captures the positive and negative aspects of this process and illustrated the experiences of disclosure for the males who took part in the study. The second master theme ‘Searching’ evolved from the narratives of the participants who described the process of searching for support as adult survivors of CSA. The third master theme ‘The Help-Seeking Journey’ brings together themes relevant to engaging in support or therapy, with a focus on relationships, and the helpful and hindering aspects of help-seeking as described by the participants. The final master theme ‘Continuing the Journey – Making Sense and Moving Forwards’ highlights participants’ sense-making and reflections of their individual journeys, and their experiences of recovery as being a an-going process. For the purpose of this research, the names of participants have been changed to ensure anonymity and confidentiality. All participants will be referred to by pseudonyms and quotations will be written in italics and referenced by page and line number from the original transcripts. Brackets and three dots [...] indicate that speech has been extracted as it was felt that this was not directly related to the theme discussed, or was removed to ensure confidentiality or anonymity.

### **1. Master Theme One: Disclosure**

Disclosure is presented as the first theme to illustrate the initial stages of help-seeking as captured in the interviews with the participants. This theme is split into four sub-themes:

'pre-disclosure (Dissociation, detaching and distancing)', 'secrets and silence', 'the process of telling' and 'the freedom of disclosure'. These sub-sections together examine the experiences of participants' pre-disclosure, the context in which participants attempt to make first disclosures, and share the in-depth reflections of participants recalling what it was like for them post-disclosure. At the time of the interview, all participants had disclosed childhood sexual abuse in one context or another, either by speaking out, or by sharing written material with family. The focus on this theme expands upon the act of simply telling another person about what happened to them as a child, and illustrates the intricate processes involved in the disclosure process for the participants who took part in this study.

### **1.1 Pre-disclosure 'Dissociation, Distancing and Detaching'**

Following the initial introduction at the start of the interviews, participants mostly began by describing their journeys towards the process of disclosing CSA. Evident amongst these narratives was a sense of an implicit need to remain silent, and a description of how this was made possible by the behaviour or actions of the participant. A number of participants described aspects of their behaviour that could be considered as dissociation. Others used the term to describe how they cut off from their experiences. Dissociation refers to the psychological defence mechanism of separating oneself from the traumatic memories; similarly, detaching refers to cutting off from the past, either denying a past existence or just 'forgetting' about what happened. Although each participant's story was unique, all shared the experience of keeping their abuse a secret for many years.

Participants shared the theme of distancing themselves from others, including friends and family members, perhaps as a form of protection against the potential of further abuse, or as a means to prevent others from finding out what had happened to them. Joe provides a description below of how it was possible for him to distance himself from others and create a new identity:

*When I was 18, I was brought up in care as I said; I left to join the Army. When your filling in all your forms on your first day and they ask you to put your name down...or what you want to be known as sort of thing...when I was 18 I was known as Joe, so I was Joe Bradley. I think because I was growing up a bit... but also I seemed to remember this is a new start, I was escaping all of that into a normal world, so I called myself Mark Bradley. [...] So I was*



*exploring who I was really... like, so yeah, so I think... then I told myself it didn't... it happened, but it didn't matter, that cliché. All these clichés are usually true, so yeah, and that's what I sort of said to myself, "it doesn't matter", and I was sort of like "you're a big lad now get on with it", you know I was a soldier. (Joe, P14, L8-19)*

By embracing an opportunity to change his name, Joe changed his name and explored being someone different, creating a facade that concealed the secrets of his past. It seems that by changing his name he could deny the reality of his past, and temporarily escape in to a so-called normal world. His choice of career is also noteworthy. Joe became a soldier, perhaps to enhance his masculinity: as he explains 'you know, I was a soldier', as if suggesting that he should be able to cope with his past or as he puts it, 'get on with it' (his life). Interestingly, later in the interview Joe describes how his past caught up with him in a way he was unprepared for, illustrating both his initial feelings about how he coped at the time (being able to put it away) and the later realisation that he needed to deal with his past and the psychological repercussions of being sexually abused in childhood.

Ben and Joe engaged in a variety of coping strategies in an attempt to escape their pasts, and both shared the experience of keeping people at a distance:

*I got into the drugs and that lot, and used to use to very much keep people distant apart from... drinking buds. That was it. And I've always been a person, I'll be... best friends with somebody, talk to them every day, see them every day, then one day I'll stop getting in contact. You're gone (Ben, P7, L1-4)*

*I really didn't stay long and if you connected with me for very long, and lots of people... the saddest of crimes, is when I look back how many people tried to connect with me over the years, and as soon as you got close it was like I was off. Or I would do something to stop that closeness, you know, so I would distance myself or build people up into pinnacles and knock them off and all that type of stuff, you know, all that went on... erm because you couldn't stay, because you'd be discovered. You'd be found out, they would see the real you, and all that stuff is real. And so I'd do a runner (Joe, P23, L23-26 & P24, L1-4)*

These excerpts reveal how both participants closed in the walls around them and kept people from getting close to them. For Ben, drugs and alcohol were used, perhaps as a means to block out the traumatic experiences he had suffered. By cutting off from others Ben was able to distance himself from anyone that could potentially harm him. Being alone appeared to be a strategy he devised to keep himself safe, possibly with the intention of preventing him from experiencing any further emotional pain. Joe, on the other hand, went in to the Army and detached completely from his previous life, creating a new identity along with his new career. His remark about building 'people up in to pinnacles' and then knocking them off suggests he might have intentionally sabotaged relationships with others to keep them from getting close to him. The fear of being found out and the real Joe being 'discovered' is evident, resulting in him running away from both his past and present life; this illustrated the notion of secrecy and the need to keep his past hidden. As he recounted his experiences in the interview, Joe alludes to possible regret about his behaviour with his reference to the 'the saddest of crimes' when referring to the people he pushed away and the opportunities he missed out on. Joe considered his behaviour as common amongst survivors of CSA:

*I'm almost a classic cliché of the survivor male or female, who goes through childhood, um then goes into adulthood and survives and adapts, almost dissociation... is a rather strong word isn't it, but puts it away and erm gets on with life. (Joe, P1, L15-17)*

By associating himself with the 'typical survivor', Joe is able to justify his behaviour as a normal response to his situation. Looking back on his life he implies that he, himself, was able to survive, adapt and put his experience away in a box, then 'got on with life'. In contrast to this perspective, other participants described the need to use various methods to cope with the repercussions associated with CSA, before they began help-seeking, as Dan illustrates:

*I mean that it's you know, destroying you, you know, a lot of that... and being happy to live in a gutter as a kind of coping mechanism, it was a coping mechanism, a kind of loss of identity, and it was a coping mechanism....I mean along with the heroin obviously. (Dan, P4, L17-20)*

In contrast to Joe who created a new life, Dan's comment 'destroying himself' implies engaging in a form of self-sabotage, and it could be considered that, for a time, he perhaps

gave up on life. During the interview, he described how he ended up living on the streets and became addicted to heroin until it became possible for him to find alternative forms of coping.

In contrast to these experiences, one participant mentioned that he was able to 'forget' what had happened to him:

*I just forgot it for a long time. (Barry, P6, L18-19)*

The act of 'forgetting' could be considered as similar to denying it happened, and for Barry, if he 'forgot about it' it is possible that he was able to focus on other aspects of his life. By removing the experience from his mind, he could free himself from the emotional suffering. However, for other participants, it was evident that forgetting was not an option, as Joe clearly describes:

*I remember she's (Esther Rantzen) speaking about it, and watching her, like, not disassociation... it's someone else. Sort of like, you know it's someone else... that was another life, that expression. It really was like that with her. So I knew it was connected to it... you wouldn't have known by my... you wouldn't have known because you just don't show. Because that was never gonna show... in fact my wife didn't know till 2000 and I got married in 81. (Joe, P15, L5-10)*

Joe reveals how, despite cutting off from his past life, a sense of it always remained in the background, suggesting that perhaps his memories did not fully disappear from his consciousness and that he could never escape from them entirely. As the past intrudes on the present, prompted by the subtle triggers from watching a television programme, Joe is forced to face the reality of his past. The latter part of his comment illustrates the notion of secrecy, and his determination ('because that was never gonna show') to keep his experience of sexual abuse hidden from everyone, including his wife.

This sub-theme captures the essence of participants remaining silent to escape from their traumatic pasts. Using a variety of methods, participants denied, detached or dissociated from the memories of their abuse, and tried to get on with their lives. Here, the idea of

survival living is apparent. This refers to the notion of just getting by in whatever way possible, in the face of coping with any psychological repercussions from the past. In an attempt to escape from the past, several of the participants described creating new lives and new identities. For some, this worked for many years. By denying or detaching from their experiences and emotions, or creating new identities, participants were able to hide or suppress the experience of CSA prior to their first disclosure.

## **1.2      *Secrets and Silence***

The second sub-theme ‘Secrets and Silence’ captures participants’ reluctance to speak out about their experiences of CSA and reveals the implicit need to remain silent. Secrets and silence was further separated into two themes: ‘delaying disclosure and keeping “it” quiet’, and ‘something triggering or enabling’ disclosure. Participants who delayed disclosure reported doing so both consciously and unconsciously. This was associated with a number of factors, including fear (of speaking out), protecting themselves and others, and not being able to share with or trust anyone. ‘Something triggering or enabling disclosure’ illustrated how at a certain point in the participants’ lives, something triggered or enabled them to disclose their experiences.

### *Delaying disclosure and keeping ‘it’ quiet*

Participants made a number of references to the need to remain silent about their abuse in childhood. An example is illustrated by Dave, whose strict religious upbringing contributed to his inability to disclose that he had been sexually abused by a close male relative:

*I never felt... I never felt safe around anybody in a sense in terms of, I never felt I could really talk and open up to anybody and that's a tragedy for a child... so I kept, I kept the memories, I kept the experiences all buried until I was, yeah until I was thirty eight. (Dave, P4, L6-7 & 11-12)*

Dave’s excerpt captures two themes shared by all of the participants: ‘the reluctance’ to speaking out and the length of time it took to speak out (delayed disclosure). Dave illustrates his vulnerability with his statement ‘I never felt safe’; this could have been due to the fact that his perpetrator was a close male relative, or due to his strict religious upbringing. Both of these together perhaps left Dave feeling powerless. During the interview, he discussed how whilst growing up, ‘sex’ was a forbidden word, never brought up in the family home. As such,

this potentially created conditions that enabled the perpetrator to take full advantage, knowing that Dave would be unable to speak out. As is revealed later in the interview, Dave's family were unsupportive following his disclosure, preferring that he did not discuss such things with them. With this in mind, it could be considered that Dave's remark 'that's a tragedy for a child, not having anyone to talk to' is indirectly illustrative of his own feelings about his childhood. Like Dave, several of the other participants recounted similar experiences when asked if they had been able to disclose to their parents:

*Researcher: "And you never told?"*

*Jack: "No no, no no no, that would have been the kiss of death." (Jack, P12, L1-2)*

Referring to the idea of speaking out, Jack implies that would be the end for him, 'the kiss of death'. Perhaps he is referring to the potential end to his relationship with his parents if he had told them about being abused. His powerful words highlight that it was never an option for him to speak out. Likewise, Sam revealed an essence of fear when talking about his reasons for delaying disclosure:

*When it happened I was afraid to say anything erm. I guess you know more about it than I do because I can only speak from my experiences but as a child... you feeling one thing but if you say something you know the consequences of what it's gonna do to the rest of the family is gonna be even worse and that's your fault. So I kept quiet. (Sam, P2, L19-22)*

Sam illustrates his ambiguity about his feelings, emphasising that he was terrified to speak out, yet almost dismissing this with 'I guess you know more about it then I do', suggesting that his views and experience are perhaps insignificant. He highlighted a sense of confusion when faced with the difficult dilemma: speaking out versus keeping quiet. Furthermore, his fear of reprisal is evident, and even as a child he was aware of the potential consequences of speaking out, and not wanting to be blamed for what had happened to him. He elaborates:

*If any of them had ever known what had happened to me... you know my life wouldn't have been worth living so I kept that quiet because of that... (Sam, P12, L17 - 18)*

Like Jack, Sam associated speaking out, with 'a life not worth living'. The thought of others knowing appears to be more than Sam felt he could handle, and the consequences dire. As if the abuse wasn't enough to cope with, the perception was, if he spoke out, things would get much worse. Consequently, he remained silent for many years. Other participants shared this theme of needing to maintain the silence surrounding CSA:

*At the time I remember thinking "gosh I should do something" but I was just too afraid to do so... there was a real stigma attached to talking about this... (Jack, P4, L11-12)*

*The actual erm, silence it just think that erodes the human spirit. (Joe, P25, L25)*

Both Jack and Joe revealed their thoughts about the notion of silence surrounding CSA. Jack recalled the conflict between wanting to speak out, but being unable to due to the fear and stigma of doing so. Joe's use of the powerful phrase 'erodes the human spirit' concluded that the 'silence' is damaging, not only physically and psychologically, but on a deeper level, as if eroding the soul.

Several participants described instances of being asked directly as children about whether they were being sexually abused. They recounted denying the abuse at the time, even though they were conscious of what had happened to them, as described by Dan, who was abused by a stranger, then again later by teachers and pupils at his boarding school:

*I was asked once by that new head teacher if anything odd had happened and I hadn't been able to trust them enough to say anything. (Dan, P2, L16-18)*

Dan illustrates his complete lack of trust in others, which is understandable when considering that he experienced abuse by an adult as a young child, then again was abused by adults in a trusted position in his early teens. The impact of this shattered Dan's ability to trust in anyone and, consequently, he delayed disclosing CSA until in to his adulthood. The theme of delaying disclosure was apparent for all of the participants, with the length of time participants waited varying from 15 years to over 30 years. Several participants described making attempts at disclosing in childhood; however, these were either dismissed or ignored, and it was reported

that as a result of this, they then delayed further disclosures for many years. This is noticeably summarised by Ben:

*The next time I kind of tried to do anything about it was when I actually went to rehab to sort out the problems... which would be October 1999 so at that point I'd have been what 29 years old and it all gone on about fifteen years... (Ben, P1, L15-17)*

Ben's description of his unsuccessful attempt to disclose and the length of time until his next opportunity illustrated his clear and vivid memory of this experience; he includes specific dates, as if the encounter is firmly etched in his mind. Likewise, Joe shared a similar experience to Ben, of trying to disclose and the negative response he received:

*I think it tried to see what the outcome would be in 94 if you said it. What would happen... and what I got was, 'well don't tell me anything bad'. You know and you think 'well, where would you go, where... you don't want to go and tell somebody about all that stuff if all they are gonna see is bad... well you might be bad because you don't know, do you... if you are bad?...' because you get sort of like confused in your head about it really, you know. (Joe, P15, L20-26)*

His words 'I tried to see what the outcome would be like' suggest that he was perhaps experimenting with a disclosure to see what the outcome might be. The therapists' response 'don't tell me anything bad' left him questioning himself and his role in the abuse, potentially reinforcing the confusion that he experienced when the abuse occurred.

The above excerpts demonstrate participants' experiences prior to disclosing CSA. All perceived the need to remain silent, thus keeping their abuse a secret for many years. Along with the experience of CSA comes an implicit sense of fear about speaking out, perhaps instilled by the perpetrator, or simply due to the stigma and shame of knowing that something like this had happened to them. Participants' confusion was evident, as is shown in the excerpt by Joe, who describes questioning himself: 'Was I bad'? This was a question which crossed the minds of several of the others who struggled to make sense of what had happened to them. Ultimately, they knew that such things should not be talked about, and

buried or suppressed their traumatic memories until something triggered or enabled disclosure, as is described in the sub-theme below.

*Something triggering or enabling disclosure*

Embedded within participants' narratives was the triggering of a disclosure at a particular time in their lives. Dave's experience of this is highlighted below:

*It was just something that I suppressed, and until there was a significant moment in my life, at that age when I had a bereavement, at which point... all the memories became extremely vivid and extremely painful, and powerful, and then... that's why I started the long road of trying to find help. (Dave, P1, L12-15)*

Dave's CSA experience was described as initially something he could 'suppress' until a certain point in his life. It appears that his father's death triggered an emotional response, which led to a descent into the memories of his past, leading to the realisation of the need for help, and as Dave describes, the beginning of a 'long road' ahead of trying to find appropriate support. The death of a family member also led Dan to open up and speak out about his experiences:

*I suppose after he'd died I felt I was more free to talk about it. (Dan, P11, L20)*

Earlier in the interview, Dan described his mother as submissive and uninterested in him as a child. He stated he had a full-time nanny and that his father lived away in the Army, upholding a high-ranking position that enabled him to fund a private school education for Dan. Following his father's death, Dan states he felt free to open up and talk about being sexually abused. It is possible that Dan might have refrained from telling his parents, either to protect them from hearing what happened to him, or due to the fear of what his father might have thought or done.

Although participants illustrated their ability to suppress their abuse experiences, it soon became apparent that this was only temporary. Participants shared the intense moments at which their pasts exploded into their present lives, as is eloquently illustrated by Joe:



*She (referring to his wife) didn't know anything about the sexual abuse till 2000, when, you know there was no barriers to defend yourself against the reality of that other life. Cos it exploded into this life. You know it had been suppressed and buried for so long. (Joe, P15, L15-18)*

Illustrating the lengths he had gone to in order to keep his abuse a secret, Joe claims that even his wife was unaware. Again, he highlights the year this experience occurred, which perhaps marked the change for him in his ability to keep his abuse hidden. His words imply that his barriers came down; all his efforts could not protect him from the reality of his past life, which he powerfully describes as 'exploding' into his current life. The use of the term 'exploding' infers an overwhelming and intense experience, out of Joe's control. He elaborates on the emotion surrounding this experience:

*When I exploded I was working in mental health services and erm... exploded is a funny expression – emotionally exploded. All those buried emotions all that way from seven to seventeen and before. I thought I was going to die, you know, all those clichés, you know, it felt like... I remember the day it happened and the six o clock news... and all the films of all the people that I'd known. It was seeing the child, the faces of the children I'd grown up with, and then fast forwarding to the adult they became, in many cases erm, they didn't get very far into adulthood, really triggered a massive emotional breakdown for me.'(Joe, P16, L10-16)*

As he powerfully discusses his past coming back to haunt him, Joe reveals how a trigger, a television broadcast of an abuse case, prompted the return of the traumatic memories he had repressed as a child. The intensity and emotional pain of this experience is evident as Joe states 'I thought I was going to die'. This is further compounded by the shock of seeing familiar faces that had perhaps committed suicide, or did not make it to adulthood for other reasons. His vivid recollection of the day of this emotional breakdown and how he felt at the time highlighted how emotionally and physically painful this experience was for him. Dave reported a similar experience, as he revealed how he came to realise his need for help:

*From the moment I realised the enormity of what had been done to me I felt I needed some sort of help, but I didn't know what... I needed to talk to somebody. (Dave, P16, L12-14)*

It appears as if all became clear, the 'enormity' and extent of his suffering was realised and, as such, prompted Dave to begin the search for help. His confusion is evident: 'I didn't know what'... but he knew it was time that he spoke to someone about what had happened to him.

For several of the participants, disclosures occurred unexpectedly, prompted by either a person or being in a particular environment. This theme is captured Joe:

*I remember seeing this counsellor in the GP surgery and... To cut a long story short, after lots of the angst of the redundancy and not feeling... I was really... now looking back, it was really about all the classic stuff that survivors have about, not feeling worthy, I was to blame, not feeling any motivation to do anything that had any value, in the last session was also classic I think, where people disclose in the last five minutes of the last session, but I actually disclosed my sexual abuse because she, the therapist I think wasn't very good really and what she'd been doing, she was trying to compare me to [...] and of course I took that as being judging, judging me really, and in some ways I think it was. (Joe, P2, L15-21)*

*I went to see this doctor and I remember saying to him, saying, 'I've got this real bad kidney problem', which I had, I had a real bad pain in my kidney, so he said "okay we'll do some tests", and I said "but also I've been abused in childhood...sexually and I would like some specialist help please. I'd like to see a specialist counsellor for sexual abuse". (Joe, P3, L19-22)*

Interestingly, Joe described two different accounts of disclosing, and in both it appears the disclosure occurred unintentionally. In the first excerpt, he describes seeing a counsellor at his doctor's surgery after being made redundant from his job. As he reflects on this experience, he considers the symptoms he experienced following the redundancy as classic symptoms associated with being a survivor of sexual abuse and states he disclosed his abuse in response to the therapist's behaviour, which appeared to make him feel as though he was

being judged. Joe disclosed in the session, perhaps as a justification for his behaviour; alternatively, it could be hypothesised that he disclosed to challenge her or prompt a reaction. The second excerpt details how he went to the doctor for another reason but again ended up disclosing that he had been sexually abused. One could speculate that Joe planned his disclosure, with the aim of starting with one problem to break the ice, before moving on to disclosing CSA. It appears that Joe knew he wanted 'some specialist help', this implying he knew what he wanted at the outset. Alternatively, Joe perhaps unconsciously blurted out the fact that he had been abused whilst in the safe environment of the doctor's surgery. This was found by Ben, who found that being in a particular environment enabled him to open up about his past:

*No, wasn't an option, yeah its more for the fact that I sort of went to the clinic... after I went to the clinic the stuff started coming out. (Ben, P2, L47-49)*

In response to the question 'were you ever able to speak out?' Ben states that it was not an option for him until going in to a rehabilitation clinic. His words 'the stuff started coming out' implied a lack of control over what was happening. Perhaps the safety of the environment, and possibly the reduction in his substance use, facilitated the act of disclosure in a way that he had not anticipated.

In addition to personal experiences such as bereavements, or the environment enabling disclosure, another reason discussed was shared by Sam, who wanted to reveal his story to his family to justify his behaviour as a child:

*I decided it was about time they all knew why I behaved the way I did. (Sam, P1, L15-16)*

During the interview, Sam shared a sense of feeling vulnerable about disclosing CSA, and having previously only disclosed to close family, speaking to me was his first experience of a disclosure face to face (over Skype). Similar to other participants, Sam reached a point in his life where he felt that he was able to speak out; however, his reasons for doing so were notably different from those of other participants. Sam had been taken in to care as a child due to his behaviour and had ended up in prison for several years in his early adulthood. He felt that others' perception of him was as inherently bad; therefore, by writing about his

experience of CSA, he was able to justify why he had acted in the way that he did. Finding a way to speak out indirectly helped Sam to share his story with his family.

### **1.3 Experiences of Telling**

In the re-telling of their stories to me, participants illustrated the facets of disclosing CSA. As they recalled these experiences in-depth, vivid and evidently traumatic memories were shared. Participants appeared keen to describe experiences of first and subsequent disclosures, as if telling a story of the journey of the help-seeking process.

Vivid and detailed recollections of disclosure experiences were shared, highlighting the intensity of the memories for the participants. This process is eloquently described by Joe:

*And it, like all survivors the first opportunity you have to speak you think, to supposedly an expert, you know it all floods out, you use a form of verbal expulsion you know it's like sick, you know, letting it all out, so she just got it, bang bang bang, it must have sounded like it was a rant, you know for thirty or forty minutes. (Joe, P4, L20-23)*

There are two interesting points that Joe highlights here. First, the evident lack of control he insinuates that is associated with the act of disclosure, demonstrated by his words 'verbal expulsion'. His words suggest that the disclosure came out frenziedly, and the use of 'bang, bang, bang' imply the therapist was shot with all of this emotion pouring out of him. Secondly, Joe reveals his scepticism about the therapist, who he describes as 'supposedly an expert', illustrating perhaps his expectations of the therapist as being knowledgeable and able to contain his disclosure.

In the previous sub-theme, participants reported how disclosures often occurred unintentionally or as a response to another situation. This theme is further expanded on below, as Joe explains his 'experience of telling':

*I said "Well you know, I have also lots of other baggage like erm being abused, and I dealt with it" and I can remember it what she said, she said er "well if you want to talk about that, erm well I don't want to hear anything bad..." and I sort of like looked at her and thought "I'm not sure what would*

*be bad”, but I then shut up, and didn’t say anything, so the last five minutes of my session was silent, and I left. (Joe, P2, L15-20)*

Joe’s unexpected disclosure appeared to change the dynamics of the therapy session. His statement ‘I have lots of other baggage’ and ‘I dealt with it’ was possibly a way of trying to prove a point to his therapist, that he has been through worse and got through it; however, his experience was that the therapist did not want to hear the ‘bad stuff’. As he recalls this encounter, one can almost imagine the experience as he shares the subtle details, how he looked at her, his thought process ‘what would be bad’, the confusion he felt and then the abrupt end to the conversation and sitting in the silence that followed. One can only imagine what might have gone on for Joe during those five minutes. Her response appeared to shock him and led him to question what she meant by ‘I don’t want to hear anything bad’. He later inferred from this that she thought he might have gone on to abuse others.

Like Joe, other participants also provided intricate accounts of their disclosure experiences:

*I went and saw this guy erm... who and again I can still remember his name, who proceeded to tell me first of all basically how great he was... and what qualifications he had. I mentioned that I had gone to school at the local school which was [...] and I mentioned this to him and he went “ah my boys went to [...] as well they had a great time there”... I left there and I thought “you f-ing bastard...” and then I just didn’t know what it was all about but basically he didn’t wanna know and his kids had been to the school that I’d been to where I was telling him about my abuse and his response was “my kids had a great time....” and I could of punched him. I was just dumbstruck; I didn’t respond. I just left feeling like shit as usual you know... (Dave, P18, L15-24)*

Dave’s experience of telling a therapist about his abuse was evidently a negative one. His vivid recollection of his name suggests that he had held on to this traumatic encounter for many years. His anger is clearly expressed in the quote by his statements “you f-ing bastard” and “I could of punched him”. Dave’s own agenda, his disclosure of abuse, was trivialised by the therapist’s inferred lack of interest and inappropriate comment about his own children having ‘a great time’ at the same school in which Dave had been a victim. At a time when Dave needed undivided attention from the therapist, he was angry to find the therapist was

not focused on him but on revealing personal information about his own family. Dave also highlights his annoyance with the therapist's attitude of sharing his qualifications, which was perhaps perceived by Dave as showing off, or triggered reminders of a power imbalance that Dave might have associated with his abuser, who he describes was in a powerful position at work and amongst the local community. He described leaving the session angry and disappointed and 'feeling like shit again', let down by another person who he had expected might be able to help him. Joe provides an excellent summary which powerfully illustrates this theme further:

*I think, what people don't realise when you're expelling that, it's like expelling parts of you, you know because you hold it in so long, it's in your psyche, your consciousness, so actually exposing it to fresh air, its fresh it's like a puss coming out a bad wound. You know all those thoughts, so yeah and I was just shocked at the process. So I went away and you're not thinking rational so your mind is so focussed on "are you mad really?" and I don't know, the stuff that goes with that... high anxiety... (Joe, P5, L1-5)*

Joe clearly captures the sense of vulnerability, echoed by participants when disclosing CSA. He highlights 'others' lack of understanding about the intensity of this process, using the words 'expelling' and 'exposing it to fresh air'. His strong and vivid descriptions 'it all floods out' and 'puss coming out a bad wound' could be associated with the release of poison. Leaving the session highly anxious, Joe reflected on his own sanity and as if he was the one with the problem, again highlighting possible feelings of blame. His narrative emphasises the emotional pain of expelling his memories that he had held in so long.

Other participants were less lucid in their descriptions, and shared brief details of their experiences of telling:

*And so I just... initially I just put it all, because I like to write... because I, I'm more confident in writing than I am in talking with somebody face to face. I can say things that I want to say better on paper, so I did it basically for meself. (Sam, P1, L16-18)*

Instead of a verbal disclosure, Sam reveals how he wrote about his experiences. He emphasises his lack of confidence in speaking out, preferring instead to put pen to paper, enabling him to articulate himself. This is perhaps also a reason for the lack of detail shared during our interviews. Also interesting is the fact that he stated 'I did it for meself', emphasising his need to share his experiences, not only to justify what had happened to him, but for him to move forward.

Feeling let down appeared to be a common theme amongst the participants; Ben captures the essence of this with his description of an attempt to tell his parents about being sexually abused by his brother Barry:

*I actually came home one day and went "look I gotta tell you the stuff I'm sorting out though the treatment, I've been told it would probably be an idea to talk to you about it, I'm not going to go into a lot of details but let's just say the relationship between me and Barry was very strange, there were things going on that absolutely shouldn't have. [...] so I said "well it's up to you, if you wanna... if you feel it will be any help for you to know more but you... I'll tell you if you wanna and if you don't I won't". And about five minutes later me dad walked through the door cos it was just me and Dawn (his mother).... and Dawn turned to James and said "oh Ben's just been telling me that, some quite bad stuff going on between him and Barry when he was a kid and.... well it's obviously sexual" and my dad looked at her and went "oh alright" walked though, got a cup of tea and went and watched TV. (Ben, P3, L10-22)*

Ben was sexually abused by his brother Barry, and by Barry's girlfriend. Recounting the conversation he had with his mother, Ben illustrates his subtle attempt to highlight what had happened between him and his brother. He indicates that things were not right between himself and his brother without directly saying that he had been abused, and it is evident that perhaps his mother had some idea of what might have gone on by her statement 'well it's obviously sexual'. Ben's disclosure appears to be met with acceptance, and is unquestioned. The inherent difficulties associated with the disclosure of sibling abuse are evident here, as Ben describes his father's response, portraying the denial that surrounds this type of abuse. Ben confirms this as he elaborated on how his mother responded to his disclosure the following day:

*The next day my mum came back and went “well I’ve thought about what you said and actually I’d rather not know anything”. Ok, so they happily live in this little puddle of denial... (Ben, P3, L26-28)*

The impact of his parent’s decision, that they would rather not know, highlighted to Ben that they would not be able to offer him the support he needed. He disguised his sadness with his comment about them ‘living in denial’, but one would imagine that it must have been extremely painful for him to build up the courage to disclose to someone he cared about, and then have them tell you they do not want to know. Dave and Dan described similar experiences:

*My family basically united against me... not in denying that it happened but simply why did I have to bring it up after all these years (laughs) and why did I have to bring it up around dad’s death and I don’t think they ever had a clue as to the impact of abuse that I, I, think they probably still don’t have a clue about the real impact of it. (Dave, P2, L2-5)*

*He said “don’t tell anybody” and of course I ran home in floods of tears and told my mum all about it. And she said “try and forget about it.” (Dan, P1, L23-24)*

Dave’s laughter following the comment ‘why did I have to bring it up after all these years’ was suggestive of his utter disbelief at their response, and it is evident that he felt his family could not comprehend the detrimental impact of what had happened to him and the psychological repercussions he continues to experience as an adult. Although, as he states, his family did not deny the abuse had occurred, the very fact that they considered it to be almost an inconvenience to bring it up years later implies they felt that it was not important, invalidating his feelings and suffering and further reinforcing the commonly held view amongst participants that ‘I should have got over this by now’. Similarly, Dan’s distress was also trivialised by his mother, who told him to ‘try and forget about it’. For a child who had just been raped and was clearly in distress, hearing this would potentially have contributed to further confusion and anguish. The silence instilled by the perpetrators ‘don’t tell’ was then reinforced again by his mother. Dan later described further experiences of sexual abuse at



boarding school. It is possible that by being told just to forget it, Dan was unable to later protect himself from further abuse later in his life. He also assumed that telling anyone would not help him, as had been the case in the past. Later in the interview, Dan describes how he went from remaining silent to the opposite:

*I went through that phase of just blurting it out to everybody as I mentioned, but some people you know, I lost a lot of friends I think because some people just can't handle it if you're too splurgy about it. (Dan, P10, L19-21)*

Here Dan infers that he wanted everyone to know what happened to him. Revealing that he lost friends due to his disclosures, Dan perhaps later realised that others might have been uncomfortable with his frequent discussion about his experiences of abuse. Other participants shared a perception of finding others unsupportive of their disclosures:

*The individuals I confided in minimised it and kind of said "Jack he did nothing, what's your big deal". That I found deeply unhelpful and just made me think... "God I'm making a big deal out of this?" (Jack, P24, L12-14)*

Jack demonstrates that the responses of others can be particularly unhelpful, especially when they minimise or are dismissive of what went on, and can potentially impact one's perceptions of themselves and their role in the abuse, illustrated by Jack's words 'god I'm making a big deal out of this?' Not only were family and friends found to be unsupportive, but those in trusted positions outside of the family were also experienced as unhelpful. In particular, several participants considered that the group therapy setting would be an optimal environment to share their disclosures with others; however, instead, they experienced the group as unpredictable and lacking in support. Ben shares an example of this below as he shares his response to the therapist's question about why he had come to the group:

*"Ok yeah... from the age of eight I was abused by me brother", bla bla bla bla, and the room went absolutely deadily silent, and people waited about thirty, forty seconds, and then someone changed the subject, and so he (the therapist) started asking them about the new subject they brought up, and I thought, "ok, probably something about their fucking dog." (Ben, P9, L28-32)*

Ben appears almost disconnected as he relays his experience of being abused by his brother, sharing what one might assume is a deeply painful experience to a group. His use of 'bla bla bla bla' may be illustrative of him attempting to minimise this experience. Perhaps he did not anticipate he would shock the group with his abrupt and frank disclosure, and for this to be dismissed or trivialised would have perhaps further reinforced his view that his problems were unimportant, particularly after trying to speak out to his parents, who also stated they would rather not hear about his experience (as has been described previously). His use of sarcasm when describing this experience is perhaps used to deflect from this difficult experience and possibly another occasion, which contributed to him putting the barriers up and reinforcing his lack of trust in others. Such experiences were commonly reported across the participants' accounts. Joe eloquently describes the impact of feeling let down after a number of negative experiences with therapists:

*It woke me up in many ways to the shock and you suddenly realise you are not in the safe world where people are gonna understand and deal with your disclosure, erm, as you thought they might. (Joe, P6, L21-22)*

His expectations of how people would respond to his disclosures were different to how he had imagined, and his ideas of a safe world where people would understand him were unfortunately not the reality for him.

#### **1.4 The Freedom of Disclosure**

Despite the difficulties surrounding the process of disclosure, all of the participants found that after they had divulged their experiences in whatever form, they felt a sense of relief or freedom. This is illustrated by Dave:

*Researcher: "How did you get that determination to change things?"*

*Dave: "Well it was the disclosure that freed me up" (Dave, P22, L5 & 7)*

In a similar way, Sam described his disclosure process and the freedom of finally being able to share what happened to him:

*I've never sought help for it, apart from when I turned 50, writing about it. And that's, I decided, because my family were all dying off and they'd all got a perception of how I behaved when I was a child and it was always me that they... I was always to blame you know for, everything. So I decided it was about time they all knew why I behaved the way I did. (Sam, P1, L13-16)*

Like several others, Sam perceived the act of disclosing as a way of freeing himself from others' perceptions of him as bad. He considered his method of seeking help as putting down in words what happened to him and being able to share his experiences this way. Doing so enabled him to explain and justify to his family the reasons for his behaviour as a child. He found it cathartic to get it all off his chest and reveals how being older enabled him more insight and the ability to rationalise things he found difficult to understand when he was younger.

Dave perceived himself as having more freedom following his disclosure, however he describes his family's interpretation as very different:

*My family, their interpretation was that I was manic, and you know, I was out of control... but actually I was never in more control during the next year or so after I disclosed my abuse. (Dave, P22, L11-14)*

Perhaps changes in Dave's behaviour were perceived by his family as unusual, encouraging them to view him as manic and out of control, although, as he states, the act of disclosing left him feeling in more control than ever before.

Sam described needing to have courage to tell people and the length of time it took him to achieve this. Although it took him a long time to gain the courage to speak out, he shares how it felt good to eventually do so:

*It's good to get it out, you know... its erm... but it's taken a long time. Like I say, 53 years of age... well its taken nearly 45 years you know to have the balls to tell people. (Sam, P8, L22-24)*

Several participants expressed regret about not being able to speak out as a child; however, none of the participants reported regretting disclosing their experiences of sexual abuse. This is clarified by Joe:

*I've never met a man that's disclosed who regrets the disclosure. (Joe, P25, L21).*

This theme has captured the complexities of the disclosure process for the participants who took part in the study. All of the males described their first experiences of disclosure, whether this involved disclosing to family, friends, police or during therapy, reflecting on the responses and impact that disclosing CSA had on their lives. In addition, during the interviews, each participant went through a further disclosure process in sharing his experiences with the researcher. This enabled further understanding of their experiences. For several of the participants, disclosure was reflected on as a positive process in their recovery, enabling a sense of freedom. Others noticed that the world 'shut down on them' after disclosing. It is evident that each disclosure process is unique and, therefore, it appears there is no right time or way in which to disclose. Overall, participants experienced the disclosure process as a complex one, confounded by a variety of factors and as equally distressing as it was freeing, resulting in mixed emotions amongst the participants. Nevertheless, the majority of participants reported a sense of relief and freedom after disclosing their abuse, enabling them to begin a new journey towards help-seeking.

## **2. Master Theme Two: Searching (for help)**

During analysis of the transcripts, the process of actively having to 'search' for help was evident. The theme 'Searching' illustrated participants' experiences as they embarked on a search for help and comprises of two sub-themes: 'It's like a desert out there' and 'The dilemma of being male'. The quote 'It's like a desert out there' illustrated the participants' despair at being unable to find any support at a time when they needed it. 'The dilemma of being male' expands on the difficulties participants experienced due to being male, and the additional impact this has on accessing therapeutic support.

### **2.1 *It's like a desert out there***

The theme 'It's like a desert out there' captures the shared views amongst the participants about the lack of services and support available for male survivors of CSA. This struggle to

find appropriate help was considered to significantly impact help-seeking and contributed to further frustration and distress for a number of the participants. Participants described the process of gaining the courage to seek support, yet feeling disheartened by the lack of support available. Ben highlights this eloquently:

*I was at the point where I wanted to try and do something, I was at the point where ok, I will now try and get help, I've got this really completely fucked up belief system that I'm really battling against, and I've tried to completely disregard it and in fact do the complete opposite of it.... and now I want to try and engage in something to help build that side, rather than slipping back to that side... and then to find that there's no support available actually reinforced all the negative beliefs. (Ben, P18, L39-44)*

Ben illustrates his frustration that after finally getting to a point where he felt able to seek help, his hopes were crushed by the lack of support available. As he states, he uses this experience to further reinforce all his negative beliefs. He elaborates by illustrating his doubt about the significance of his problems: 'is he imagining this?' He then attempts to explore whether such experiences are possibly normal amongst siblings:

*Am I imagining this stuff? Because if I blocked it out for so long, is it true or the other part is, you get this whole thing about you know sexual experimentation in teenagers, yeah and sometimes between siblings and that kind of thing is spoken about, I don't know.... does that kind of this thing happen while it's not perfect yeah it happens end of... so am I actually just making a fucking mountain out of a molehill or should I just shut up, stop whining and get on with it? And then so... by having... trying to battle against that side of it... no the doors are closed, the doors are closed and actually if there are no doors open, surely that proves that you're making a mountain out of a molehill, cos if there was a problem, there'd be support available. There's not...' (Ben P18, L44-50 & P19, L1-2)*

Ben brings to light two interesting points. Firstly, his attempts at justifying the abuse, his perception that this kind of thing happens, and therefore is normal, could perhaps be a way of minimising his experience, labelling it as just sibling experimentation. Secondly, he

emphasises how he perceived the lack of resources and available support, stating 'the doors are closed', and his interpretation of this is that he must be making a mountain out of a molehill. The problem clearly is not a problem enough; otherwise there would be support available. This was a common theme amongst all of the participants, as is expressed by Dan:

*There was never any notion of therapeutic intervention of any kind (laughs)...so you know that notion of looking for help, I mean it was,... you know I mean it was just, never on the horizon anywhere... that I could see...(Dan, P2, L29-31)*

Echoing the voices of all of the participants, Dan and Ben emphasise the perspectives of the group, that therapy provision was far from adequate for survivors of CSA. The need to actively search for help was illustrated by Joe:

*You find addresses or telephone numbers, you know, out there, and you'd ring them and I found what were voice answering machines that you leave a message on, and you never get a call back. So you quickly, pretty quickly, realise that there wasn't a lot out there for men. (Joe, P8-9, L25-26 & 1-2)*

His quote encompasses the views of the participants, who all faced difficulties finding appropriate support. Searching for help led Joe to many dead ends, and recalled how he resorted to approaching services for women:

*Naively I, you know, looked at the women's services... Women's movement Rape Crisis would be the place to go to get help. So I wrote a letter, I rang up, never got an answer, [...] I realised then, that actually searching for care is much more complicated than one imagined. (Joe, P9, L4-10)*

Referring to his behaviour as naïve illustrates Joe's perception that his expectations were low, but that he had possibly exhausted all other options. Perhaps he thought that approaching services for female survivors might lead to him accessing some form of support. Unfortunately, this was not the case, leading him to the realisation that his previous expectations and hopes for finding support were unlikely to result in any positive outcomes.

Participants initially described not knowing where to go to access support, and most initially sought advice from their doctors, as illustrated by Dave:

*I couldn't find any help, you know I went to my doctor, my GP, and it was kind of "oh yes, yes I do know something about how devastating this can be but I'm not sure what to do for you... do you want antidepressants" (Laughs) "Well...not really" (Dave, P16, L1-4)*

Dave's laughter demonstrates his exasperation at his doctor's response, which was to offer him antidepressants. After making the decision to speak to his doctor about something very traumatic for him, it is possible that Dave's despair was further reinforced, as even the doctor did not know what to do for him. Participants perceived this in a variety of ways, although most common was that their problems obviously were not important enough or significant, because if they were, then surely a doctor would know what to do. The view that survivors can 'pull their socks up' and get on with life was frequently mentioned and something that survivors themselves perceived as true:

*I went to my GP, they said, they said basically "pull your socks up it was a long time ago get over it..." (Dan, P7, L14)*

The somewhat dismissive attitude of the therapist is inferred, and his comment to 'pull your socks up' implies the expectation that one should have got over this situation by now. As participants' accounts imply, the reality is that this is not that simple. Despite having his experiences discounted, Dan demonstrates perseverance by continuing to seek help:

*I did try to go to another GP, I was on SSRI's for a little while, um which kinda helps but... you know, I mean it just takes the edge of it, it doesn't stop you thinking about it I find, it just you know you think about it but cant... I've been there and done heroin, you can't... I was thinking "well if I'm going to do this I might as well take smack you know, it's stupid really." (Dan, P7, L15-18)*

Dan illustrates a sense of feeling disheartened as he acknowledges that his own methods, such as taking heroin, provided more relief than the anti-depressant medication that was offered to him. Being offered anti-depressants by doctors was frequently cited by

participants as the supposed answer to their problems. Other participants, however, experienced being offered short-term therapy which was also considered appropriate, as is described by Joe:

*I saw my GP, I didn't get any medication, but I got a, he suggested or she suggested that I get some counselling and in those days, I don't know what they do these days, you used to get a block of six counselling sessions, it's all you were allowed, six, they count them out like tablets, six tablets and you will be fine. (Joe, P2, L12-15)*

Joe's use of sarcasm infers his doubt that six sessions would cure him. Dave reported a similar experience and proposed that, if anything, this was counterproductive for a survivor of CSA:

*Six sessions at a surgery for complex childhood trauma is almost a complete waste of time, if anything it could be counter-productive if someone is able to open up and then be turfed out without going anywhere... (Dave, P25, L6-8)*

Dave illustrates his feelings about the extent of psychological support available. He clearly views short-term counselling as insufficient for complex childhood trauma. The idea of opening up and being, as he describes, 'turfed out', implies a sense of being abandoned without even beginning to work on the problem.

Participants described limited options for support; furthermore, where certain types of support, for example, survivor groups existed, strict criteria prevented many of the participants from being able to attend, as Barry described below:

*I will go to group work, I did start looking but there's no groups... within reasonable travelling distance of me... considering the area, you know... the [...] Rape Crisis does a male night on a Tuesday night once a month... and I work Tuesdays so I can't go... the other group in [...] only deals with males up to the age of 25 for some reason... I mean, if someone's abused at fifteen, they are usually about thirty before they disclose..... you know... (Barry, P28, L6-9)*



Barry exhibits his bewilderment that, as he states, the majority of men (including those who took part in this study) usually wait an average of ten to fifteen years before disclosing, yet his local groups only cater for men up to the age of 25.

Another key theme was the conflicting dynamic between wanting an experienced therapist and not wanting a therapist who proclaimed to be an expert. This distinction is described by Dan:

*I've done a lot of basic work. The level of sort of intervention I need now has got to be pretty experienced and you know... so I am looking at working with a consultant, EMDR type person rather than you know just someone that doesn't have that much experience. (Dan, P14, L8-10)*

Dan's comment implies the working-through stages of a process: having done the basic work, he is now looking for something more intense. He talks about EMDR (Eye Movement and Desensitisation Reprocessing), a form of psychotherapy that aims to alleviate the symptoms of post-traumatic stress disorder. From this statement, one might interpret Dan's need for a 'consultant' as a sign that he feels those less qualified cannot help him overcome his problems. Like Dan, several other participants considered that the majority of health professionals had limited knowledge of how to help them, leading them to infer that they needed specialist help. This was further contributed to by the fact that these were men looking for help, as is described in the sub-theme 'Being Male' below:

## **2.2      *Being Male and Searching for Help***

As participants talked about searching for help, they identified issues related to being male that they felt prevented them from obtaining the support they needed. 'Being male' was considered to adversely impact help-seeking, and provisions of support for men were described as woefully inadequate and significantly lacking in comparison to those provided for females. The majority of the participants reported that many of the health professionals they approached did not appear to understand the issues they presented with, or were lacking in knowledge about how to help male survivors. This is described by Dave:

*That's why I started the long road of trying to find help for me, as a bloke. And discovering actually, a) there is not much out there and b), that a lot of the*

*people who are out there, are pretty clueless about what to do to help... survivors of abuse or particularly male survivors of abuse... (Dave, P1, L14-17)*

Dave described the process of help-seeking as a long road, emphasising the idea of a journey. He uses the term 'a bloke' to emphasise the notion of help-seeking as a man, thus implying a distinction between what was available for females. Similarly, Dan and Ben commented on how, at the time, the focus was more on female services:

*I was starting to see that there was stuff being done, but still it was within the context of the feminist movement and not much stuff for blokes... (Dan, P5, L18-19)*

*No one could actually think of anyone anywhere remotely local who would do stuff like this and it was, if you're a woman fine, no problem, take your pick I can give you twenty addresses within a two mile radius, but there's nothing for men. (Ben, P11, L14-16)*

Ben demonstrates the challenges he faced in finding local support. He too felt that finding support as a woman would have been easier. In addition to the lack of support available, Joe describes below how men are not given the message that help is out there:

*Even now, yeah I mean you can find it... but we don't send messages that even when it does exist, there's no, the messages are... not sent to men... (Joe, P11, L12-14)*

In contrast, several other survivors, in particular, Sam, voiced the opinion that seeking help as a man was not even contemplated:

*I guess I should have sought help in my early years but I think... it's a sort of masculine thing... you don't wanna come across as you know weak, or you don't want to admit what's happened to you...(Sam, P3, L9-11)*

Although Sam identified that he should have sought help when he was younger, it seems that the thought of admitting that he had been abused appears to be too much for him to bear. It is possible that for him, this makes the experience more real, therefore denying it is easier

than accepting what happened. He highlights the prevailing view about masculinity and men seeking help embedded in the narratives of the other participants, associating being weak as not being manly. He goes on to share his perspective on men seeking help:

*I think most men, it's just, they are just embarrassed. It's extremely embarrassing. Erm and scary because you know full well once it starts coming out it will all come out then you start bloody crying and you think I'm acting like a girl. No offence. Erm... you don't want that, and especially if you think you've got over it (Sam, P9, L8-11)*

Sam proposed that most men are embarrassed to talk about CSA. By alternating between the concept of 'most men' and 'I', Sam can distance himself, relating what he is saying to others. It could, however, be considered that Sam is afraid to speak out, because once he starts, the emotions will flood out and he won't be able to control it, let alone maintain his masculine presence. It is possible that Sam feels exposed showing any weakness and he associates tears with being feminine. By avoiding seeking help, Sam can continue to think 'I've got over it'. His reluctance to seek help is evident by his comment:

*I think it's a bit like men stopping people in the car and asking for directions... they won't do it. (Sam, P9, L1-2)*

This statement suggests that Sam regards men in society as problem-solvers and, as such, they should not be dependent on others for help. For Sam, men should sort things out and fix their own problems. It seems that displaying behaviours considered as weak are in conflict with his ideas of what it means to be a man. Jack shared a similar viewpoint:

*It's a threat to their masculinity that your admitting there is something that happened to you. I think it's an admission that you know you weren't able to protect yourself at that age so what kind of, that doesn't make you a man you know... you were a kid at the time and then to talk about it, it's like you are making a big deal of that... why you making a big deal of this, you know this is your past... and you're a man, you should have dealt with that. (Jack, P26, L9-13)*

Jack identified with the issue of masculinity, and in his experience, men should not need help; men should be strong and protect themselves from threat or danger. Describing this conflict, he seems to suggest the dynamics impacting men and how men are socialised and the impact of this on seeking help. He illustrated his feelings about being unable to protect himself, implying that he thought he was perhaps weak. This is a common theme found amongst the participants. Jack also described struggling with thoughts that he might be homosexual:

*I think there is just a massive stigma of, you know something like this happening... you think god I'm a homosexual and there's that, at boarding school there's this whole fear, this homophobia. (Jack, P19, L15-16)*

For all of the participants, it was evident that speaking out about experiences of sexual abuse was extremely difficult for them, even more so, as Jack described, because of the issues surrounding the idea of what it is to be a man, masculinity and the stigma of people assuming you might be homosexual if you experienced sexual abuse. Dave expands on this, sharing one of the common myths that have been associated with male survivors of CSA:

*It is very emotional and the stuff that comes up there is trying to explain, I mean particularly for male survivors, which I don't mind talking about but, that if your body responds then you enjoyed it and therefore it was your fault, that kind of stuff. (Dan, P22, L26-28)*

Although Dan now feels more able to talk about his experiences of CSA, he feels that a pertinent issue for male survivors to be aware of is the myth that if your body responded, you enjoyed the abuse, and are therefore partly to blame. In his work he has set out to dispel this myth and educate survivors. He goes on to share further myths associated with male survivors of CSA:

*If you talk about it might be assumed you're a perpetrator, you know there is that one, that myth which I have, which I did, I can remember struggling with that. Um and I have, there was a stage I went through when I talked about it loads and people said, "oh I mean", you know because I've had stones thrown at me in the street and kids going "you paedophile" I mean you know that kind of stuff, and in clubs, I used to go out clubbing but I don't so much now*

*but people say, because I was at a splurgy stage, "paedo, he's a paedo..." not nice. Erm but that I think that is a peculiarly male side of it, women aren't assumed to be perpetrators and men are. What else, I suppose, yeah that, that just, it's a long time ago but that, that is the standard response and the... "Did you enjoy it" (Dan, P23, L21-28)*

Dan talks openly about how he felt others perceived him following his disclosure. He shared his need at that time to speak out about his abuse, then struggling with the idea that people might have assumed he had gone on to abuse others and calling him a 'paedo'. He highlights that this 'is a peculiarly male side of it, women aren't assumed to be perpetrators and men are', another factor that might contribute to the continued silence in many male survivors. Dan shared what he considered the standard response to a disclosure: 'did you enjoy it'. One finds it hard to imagine what impact being asked such a question would have. Ben later highlights a similar theme. It was assumed that because he was abused by a female that it wasn't really abuse, and that he must have enjoyed it.

All the participants described significant issues which appeared to affect them because of their sex. These varied from seeking help as a male survivor, to issues involving sexuality and masculinity. These quotes illustrate the difficulties experienced in searching for help as a male survivor and how the lack of support and services available for men was interpreted by the participants. Despite this, many continued to explore options for help and support, showing resilience and perseverance. From this research and the literature, it is evident that disclosure and help-seeking is a huge step forward for many survivors, in particular, male survivors; therefore, not being access to help at this time may further exacerbate their ideas about men and help-seeking.

### **3. Master Theme Three: The Help-Seeking Journey**

Participants' experiences emerged as a journey and have been presented as such. In the third theme, areas of significance along that journey have been described. Participants talked of their relationships within the therapeutic setting and the process of developing new relationships, negotiating boundaries and overcoming difficulties experienced in the therapy room. The help-seeking journey comprises of the sub-themes 'Relationships (Developing, Negotiating and Managing Problems)', 'Hindering Aspects' and 'Helpful Aspects'.

### 3.1 Therapeutic Relationships (Developing, Negotiating and Managing Problems)

Therapeutic relationships (developing, negotiating and managing problems) examines participants' experience of developing therapeutic relationships, negotiating boundaries and managing and overcoming difficulties in therapy.

The theme of relationships was evident amongst participants' narratives. In particular, the dynamics of developing, negotiating and managing problems in relationships in therapy were discussed. The majority of participants described initial difficulties in developing therapeutic relationships for a variety of reasons. Dave shared how his embarrassment led him to hold back in therapy sessions:

*At the beginning I had a couple of young and pretty inexperienced people and I also, I also find it sometimes a bit embarrassing talking about stuff and, and I always wonder what they are thinking you know, and so on and so you hold things back sometimes I think. (Dave P25, L24-27)*

Dave's preoccupations are evident, as he described wondering what the therapist thought of him. This could be associated with implicit messages instilled in Dave by his perpetrator, who would frequently tell Dave he was not good enough or was a bad person. Dave also felt embarrassed talking about 'stuff', possibly content of a sexual nature. Similar feelings were described by Barry, who voiced his discomfort about sharing information of a sexual nature with a female therapist:

*'There will be some men who won't feel comfortable around females... and vice versa... you know... because at one point when I was having counselling with Sally.... I certainly didn't like telling her about the gruesome bits about the sex stuff... I didn't mind talking about my relationship... I didn't mind talking to her about some of the relationship with my step-dad and the physical abuse that happened to me at boarding school, I would say about the sex bits but in a very sanitised, very skirted way. (Barry, P37, L2-6)*

Barry described almost having to censor what he wanted to share, possibly as an attempt to 'protect' Sally (the therapist) from hearing the traumatic detail of his abuse. The implications of Barry holding back led to him searching for another therapist with whom he could discuss

the censored material with. He elaborates on how he set up the boundaries he needed to enable him to talk about context of a sexual nature with a male therapist:

*I said when I started at the beginning ... "I'm having these flashbacks, I want to express them, I want to talk about it... some things are very gruesome, some of them are very near the knuckle, and some of my language might be foul because I've got a lot of anger to get out... are you prepared to take that on?" and he said "yeah." (Barry, P37, L14-20)*

In being able to state what he needed from the therapist, Barry created a contained space for himself where he could let all the emotions out. He questions his therapist as if to check 'are you ready and willing to hear this?' Joe, however, wasn't concerned about the gender of the therapist:

*What I was interested in was that they knew what they were doing, but I didn't really care if they were male or female to be honest with you, it wasn't an issue for me. (Joe, P7, L10-11)*

Being familiar with the National Health Service from his work in the area, Joe is clearly aware of the restrictions on availability and flexibility of therapists. He states that he didn't care about the sex of the therapist, but he wanted someone who knew what they were doing. Other participants described similar, and the notion of doubt about whether anyone actually did understand them was evident, as illustrated by Dan:

*Although he was, you know... claimed to be experienced in working with survivors, you know "come on mate, you don't really know do you?" (Dan, P19, L3-5)*

Dan's scepticism is evident, and his use of the term 'mate', said in a sarcastic tone, further emphasises his doubts. On the one hand, Dan felt he needed to see someone with expertise:

*It became apparent that I needed someone with a bit of expertise... (Dan, P8, L12)*

Yet he struggled with the notion of the 'therapist as the expert':

*That's what I struggle with, you know that somebody is going to tell me they know what is going on in my brain...and they don't. (Dan, P21, L22-23)*

The underlying perception is that no one can understand Dan's experiences. The thought of someone being able to help him raises questions. He infers that no one can possibly know what is going on for him, which leads to him continually searching for different forms of help and support. The dilemma of wanting someone who knows what they are doing, yet not wanting the therapist to come across as the expert, was common amongst other participants' accounts.

Participants shared the theme of testing their therapists. This was associated with trust, as illustrated by Joe:

*When I first went into the session erm I think for the first two or three sessions he basically got interviewed, you know and he was asked lots of questions and very erm you know, automatically you presume that therapists will automatically, I think a lot of therapists automatically think they will be trusted, I think the good ones know trust really is a real thing. It's not a theoretical thing. (Joe, P7, L12-16)*

In essence, it seems that Joe wanted to make sure that his therapist was the right person for him, which is not uncommon for clients attending therapy. Perhaps after experiencing a number of difficult encounters, he took it upon himself to make sure that future therapists would be right for him. He refers to the 'good ones', as in therapists whom he felt were better than others, and the notion of allowing trust to develop, rather than expecting it from the start. Joe emphasises the importance of trust for him, as a real thing. This resonated with the other participants, who felt that trust was a key aspect of developing relationships. In addition to Joe's interviewing of therapists, he described also looking for someone who would not feel intimidated or overwhelmed by him:

*You'd have to not be intimidated by the alpha male, masculine pretence that I probably have. (Joe, P15, L4-5)*



Seeing Joe for the first time, I felt he did present as quite masculine, and he had a deep, strong voice. Interestingly, he used the term 'masculine pretence' to describe his presentation, implying that he puts on a facade in front of others. Such behaviour might be considered a form of self-protection to prevent potential abuse from others; alternatively, it could be hypothesised that Joe developed the masculine persona as a defence against his real self. Along the same lines, Ben illustrates how he displayed an almost aggressive and challenging attitude:

*So, because I was such an obstinate bastard, completely deluded belief system and you've got some tosser going "I'm an expert in everything", I'm like "go on then, fix me ya fucker I bet ya can't" (laughs). (Ben, P8, L45-47)*

Ben's phrase 'some tosser' denotes his feelings towards the therapist, who he implies is proclaimed to be 'an expert'. Of interest is that he identified his stubbornness, and deluded beliefs, highlighting a degree of self-awareness, yet something about the therapist appeared to trigger the invitation of a challenge. At the same time, this highlights Ben's ideas and possible expectation of being fixed, or perhaps the challenge that the therapist would not be good enough to fix him. It is possible that Ben's previous experiences with therapists and the negative experience he had after disclosing his abuse left him sceptical about those in the helping professions and, as such, he might have become even more guarded when developing new relationships. He later stated that the only way in which he would trust someone is if they opened up to him first. In previous sub-themes, Ben illustrated his need for power and control in the therapy setting, and, again, his statement here alludes to a similar theme:

*He kind of knew that the only way to get me to trust him was by him trusting me first and him opening up and to almost spilling his guts first. (Ben, P10, L20-22)*

For Ben, it is evident that trust is something that has to be earned or demonstrated to him before he is able to trust others, or perhaps before he is willing to trust others. Both are plausible. Like Ben, Dave reported similar experiences, and was explicit about his lack of honesty with therapists:

*I've yet to meet someone, and I'm having some therapy at the moment, private, I've yet to meet someone yet that I really feel I could be completely and utterly and totally one hundred percent honest with. (Dave, P25, L27-29)*

Dave was explicit about his inability to be honest with therapists. One might assume this could be due to a lack of trust, or perhaps he is ashamed and unable to voice the truth. This raises the following questions: Why is he unable to be honest? What is he looking for in a therapist that would enable him to be honest? And is it really necessary to be completely and utterly honest? One can only speculate on answers to these questions. Other participants were more concrete in identifying what they needed from therapists, as is further described in the sub-theme 'Helpful Aspects'.

The development of therapeutic relationships also appeared to suffer due to the issues associated with money and payment for therapy. The following detailed quotes by Ben illustrate two similar but distinct issues:

*I partly used to be,... have this thing of "no you only listen to my shit because your paid to" end of story.... and partly I used to use it as a safety thing but partly it was like that just proves none of this matters anyway, I mean it's completely impersonal to you...fuck it.... But I think partly the fact as well after I... after I walked out and he didn't try to contact me there was a little bit of me that thought "I'm not just another retirement fund for him, he doesn't just want me coming in for money..."(Ben, P19, L45-51)*

*Even after all the private insurance had stopped paying and I was paying about 100 pound an hour for therapy, I would pay as I walked in because that gave me the freedom to leave at any point. So sometimes I would pay a hundred pounds and stay five minutes and leave. Because it's kind of like, "no I'm phasing out, I'm gone". That's it and just leave. (Ben, P19, L17-21)*

In the first quote, Ben describes how he struggled with the notion that someone might be able to understand his difficulties or listen to his 'shit' partly because he felt the therapist was only seeing him to make money out of him. He described how he overcame this assumption

after he walked out of a session one day and the therapist did not immediately make contact. Ben perceived this as being worth more than just a financial incentive for the therapist and was then able to begin to develop a relationship with him in which they could begin to work on his difficulties. The second quote illustrated the power dynamic Ben set up within the relationship by paying at the start of the session. Ben's statement of 'I don't owe you anything and can leave at any time' demonstrated his need for control. Likewise, Dave talks about paying for therapy, highlighting that this can impact the dynamics of the relationship:

*I just said you know "are you doing anything exciting over Christmas?", and he went "perhaps" and he wouldn't engage and when I left, that was when I was determined I wasn't going back... I thought "you bastard, I've just paid you fifty quid and you wouldn't even say" you know, and we had a laugh about that a couple of days ago when he referred to that session and he said, he said "that wasn't one of my proudest memories or something like that."*  
(Dave P30, L15-20)

Dave also highlights a significant theme of 'I'm paying you' and his expectation of the therapist to answer personal questions. Money and gifts are sometimes used by perpetrators as a bribe and perhaps this triggered off difficult emotions for Dave. He continued by sharing his feelings about what he expected from the therapist:

*I wasn't trying to delve or pry, all I wanted him to say was "oh we're having a quiet Christmas at home... or yeah, I'm going skiing with my kids or something."* (Dave, P30, L24-26)

Dave captures clearly one of the common issues that can arise in therapy: how a therapist responds to personal questions about themselves. Perhaps all Dave wanted was to feel normal, and to have a normal conversation, possibly to distract himself from the session. Alternatively, Christmas might have been a difficult time for Dave, with the prospect of a break from his therapist, and perhaps the anticipation that he might have to spend time with family members left him feeling vulnerable and in need of some distraction. All are speculated possibilities. The notion of therapists divulging personal information presents a difficult dilemma and raises the issue of therapists needing to be transparent with their

boundaries, what they will and will not discuss, particularly when working with survivors of CSA who may interpret such boundaries as a negative response to them.

Both Ben and Dan described detailed experiences of overcoming difficulties in therapeutic relationships; examples are illustrated in the quotes below. Also noteworthy is the divergence between how participants articulated their accounts, with some sharing vast detail and others brief statements:

*I'm really good at taking stuff and using it to reinforce beliefs... I could... stuff that...anything that Jack (the therapist) said I could completely turn on its head and in the end say "no that proves what I said" and he would just sit there and go... "What the fuck do you think I'm gonna do now then? I don't know what to do?" It wasn't till one time when we'd been doing something... talking about something and I started to do that and he goes "right ok... explain to me how this one works...". "I was like "ok..." so I started explaining this whole belief system and how it was a cycle and this fed this and this proved that bit and in end he was just sat there and he started sort of like chuckling a little bit and in the end he was laughing so hard bright red face with tears coming down his eyes, and I of course I was like pissed off, I was like "what's that about?" and he goes "Do you practice being such a cunt?" (Ben laughs). Completely took the wind out of my sail and I just walked out, and that's how set I was in stuff. (Ben, P19, L6-16)*

Ben illustrated how his initial stubbornness and inflexibility impacted the dynamics of therapy. It is evident that Ben initially attempted to justify his belief systems and ways of thinking to his therapist Jack. It also appears that he wanted to challenge him in an attempt to reinforce his beliefs. Being confronted by Jack and asked directly about his behaviour clearly shocked Ben, and although he laughs about the experience of his therapist asking if he 'practices being a cunt', it is evident that this took him by surprise and had an impact on him. He was later able to look back and see how adamant he was about proving his own self-beliefs to be right.

A further example of overcoming difficulties in therapy is illustrated by Dave:

*So I went back to see him and I told him what had annoyed me about him and what had made me kind of leave if you like... erm which was... erm he he he made a couple of comments that I struggled with erm... one was that did I fee, he asked me “did I feel that I was someone who quit easily or did I have a history of quitting?” and I, so I challenged him over that one and err... you know and again it was more my sensitivity, my ultra sensitivity than him saying “you’re a quitter”, it was just me picking up on the... almost the abuser saying you know “you’re a quitter...” (Dave, P30, L5-10)*

The hyper-vigilance and sensitivity a number of participants experienced is captured eloquently by Dave above. He demonstrates how a seemingly innocent question posed by the therapist triggered messages he had internalised from his perpetrator: ‘you’re a quitter’. The significance of this encounter highlights both the potential damage, but also the beneficial aspect of being able to return and discuss this issue with his therapist. Describing their shared laughter following this experience, it is evident that this encounter ended positively. Jack, however, shared a very different experience, which did not end positively for him:

*I was struggling to connect with all these feelings...er then when I found out this thing about the therapist doing this to this you know person I was in group with, it brought up all this anger because he was another male father figure individual who you know even though he didn’t do it to me, err he you know it was, I found it devastating. (Jack, P13, L21-22, P14, L1)*

He revealed how his own struggle to connect with his feelings was further impacted when his therapist ruptured the alliance between them. He was shocked to find out that his therapist, who he considered a ‘father figure’, was having a sexual relationship with one of the group members, and felt violated; again, the trust he had in another person was shattered. Jack ended the relationship:

*I said “you know I can’t see you anymore.” (Jack, P14, L2-5)*

He understandably chose not to return to the group following this experience, suggesting that the violation he experienced had severed their therapeutic relationship.

The above excerpts demonstrate the benefits and challenges of developing relationships with therapists and helping professionals. The accounts reveal that trust is integral for developing an effective therapeutic relationship within which to begin to work on the traumatic experiences shared by the clients. Overcoming ruptures was also a salient theme, and in many cases, enabled participants to reflect and learn more about themselves and in overcoming ruptures develop trust in their therapists.

### **3.2     *Hindering Aspects***

Participants were asked about difficulties they encountered when seeking help, and asked to describe anything they felt hindered this process for them. As such, a variety of ‘hindering aspects’ were revealed, including the financial burden of having to fund one’s own therapy, or further therapy beyond what was offered by the National Health Service (NHS), a theme shared by Ben, Dave and Dan:

*The... the therapy I’m having at the moment, I’m having two sessions a week and its private, its fifty pounds a time, it’s a lot of money...[    ] And if I was on benefits or wasn’t earning a decent wage that sort of money would just be way beyond what I can afford. If you’re on benefits its way beyond what you could afford. You couldn’t pay fifty quid out of that... (Dave, P28, L4-6 & 10-12)*

*Researcher: Were there any other services you found?*

*Dan: Not that I could find that weren’t I mean, except for what you could pay for... and quite a lot of money paid for, which I didn’t have, a lot of money you know, I was sort of 25 a session I was paying [...] it is a lot of money on a manual labouring income. (Dan, P9, L24-29)*

Both Dave and Dan illustrate similar perspectives on the financial burden of funding therapy. This was considered a potential barrier, particularly for those who felt they needed long-term therapy but were unable to afford it.

Participants regarded negative experiences with therapists as particularly damaging. Some of the shocking excerpts revealed illustrated inappropriate comments and behaviour.

Dave provides an example of this:

*I'd mentioned my, err... my Catholic upbringing and one of her suggestions was um that I considered going to confession and getting it off my chest... so again obviously my fault (laughs in disbelief) go to confession... to confess my sins... of this bastard abusing me you know.. (Dave, P26, L2-5)*

Dave expressed his shock about his therapist's suggestion of going to confession. It could be hypothesised that Dave might have associated the idea of going to confession with the abuse being his fault, as generally, when one goes to confession; it is to repent their sins. Perhaps the therapist might have been innocently suggesting another place in which to share such feelings; however, this clearly had an adverse impact on Dave, leaving him understandably angry.

In detailing their experiences, several participants re-enacted encounters with therapists or therapists' behaviours towards them, perhaps to illustrate a sense of how it felt for them at the time. An example of this is provided in Dave's quote:

*I had the most horrendous experience with her... she... she came out with some stuff that was just so incredibly inappropriate that it shook me. Erm she said things like erm.... erm she kind of leant towards me, and I'm doing this for effect not for real, she waved her finger in my face like that (wags finger in my face) and said "I don't understand why you didn't stop it" this was a woman, a so-called psycho... she was the director of psychotherapy actually, head of the department. She was pointing in my face saying she doesn't understand why I didn't stop the abuse that was occurring when I was seven or eight, and at the time when she said those things I remember thinking 'oh my god yeah why didn't I stop it' you know, again I was dominated by this person. (Dave, P23, L15-23)*

With the emphasis on his body language and changing his tone of voice, Dave demonstrated the behaviour of his therapist towards him in that particular session. The intrusive nature of the therapist's behaviour is evident by the description of her physical movement, closing in on Dave, and the wagging of her finger, which could be considered as attacking and intruding

on his personal space. He demonstrated this during our interview and I immediately identified with his feelings. There is no doubt that this encounter was re-traumatising for Dave, leaving him feeling subjugated. He then described reverting back to blaming himself for not stopping the abuse occurring. Ben experienced a similar encounter, describing how a therapist's behaviour left him feeling vulnerable in a group setting after being asked his reasons for coming to the group (described in the disclosure section). The lack of response from both the group and the therapist left him feeling reluctant to speak out in a group environment again:

*I think that's partly why as well I wouldn't talk to him, I mean ok, you dug me a whacking great hole, you put me right in there, and then when people obviously became uncomfortable, look you done it for whatever reason, but people were obviously uncomfortable with it, you've reinforced their behaviours of ignoring it, changing the subject, sweeping it under the carpet, fuck you pal. Why should I trust you again? Which wasn't very helpful in terms of dealing with stuff, cos I was like... ok ,I've already got huge trust issues because you can't trust your family, the people who are supposed to be there and protect ya, are actually the ones who make your life hell and put you in harm's way. And now you want me to trust you, and you're doing that as well. Guess what, no! Aint going there mate, see ya. (Ben, P9, L40-48)*

In recounting this experience, Ben reveals his anger about how he was treated in the group situation, in particular, how he felt as though he had been set up and his issues minimised and swept under the carpet. This, as he infers, further contributed to his difficulties with trusting others. His anger and hurt is evident by his words 'fuck you pal' and it seems he shuts down again, putting up the barriers after his trust in the therapist was violated. Following this experience, Ben stated he avoided any further group therapy.

During the interviews, it was apparent that participants were reliving encounters from their past; in doing so, their thought processes about their earlier experiences were revealed. Joe for example, spoke about a therapy session which confused him, perhaps in an attempt to understand this experience:



*What I found strange was she never stopped and asked any comments during the whole process, at the end it was like she looked at me, and she was like, she said "Well, thank you very much for coming, you can go now" (Joe, P4, L23-25)*

Here, Joe shows that a therapist's behaviour or attitude can influence a client's thought processes. He infers his curiosity as to why she did not question him further about his experience.

Dave, who had experienced a number of episodes of therapy, reported the significantly negative impact of a therapist who failed to be collaborative:

*She didn't want to talk about the childhood stuff she was more interested in the here and the now..." and the effect that my father's death had had on me... [...] it wasn't what was troubling me, it was childhood that was troubling me but she didn't wanna go there.... and erm, I left the hospital that day and I felt seriously depressed and I remember at the time walking towards the bus stop or the car park however I got there or how I was getting home... and I remember thinking should I go and jump in front of a bus or a train because it was obviously my fault' (Dave, P26, L6-16)*

Dave illustrates the conflicting agendas of client and therapist, and how he wanted to concentrate on one issue, whereas the therapist suggested focusing on something else. He highlights a common theme associated with short-term therapy: the focus on the present. Dave, however, evidently wanted to discuss his childhood. The lack of collaboration and disagreement about Dave's problems appeared to contribute to his feelings of depression, and he left the session with thoughts of suicide. On a similar note, the significance of the unequal dynamics in the relationships between therapist and client was a theme also raised by Dave:

*No one wants to know, and now you've got someone who's a big Dr Person telling you that it's actually your fault (Dave P24, L17-22)*

Dave concludes that no one wanted to hear about his problems; but to make matters worse, he perhaps perceived the doctor, who he referred to as a 'big Dr person', as blaming him for the abuse occurring. Ben was just as lucid in sharing a similar perspective:

*It was just something about him, he was just like... I think its cos he was one of these people with lots of certificates over the walls and I'm an expert in this one and expert in that and I, I was an obstructive bastard (laughs). (Ben, P8, L29-32)*

For both Dave and Ben, the perception of the therapist as an 'expert' put them off. Ben acknowledges his own barriers and is clear about them, he knows he is stubborn. It seems the idea of the 'therapist as an expert' might have encouraged Ben's obstructive side to present itself, potentially hindering the initial development of a therapeutic relationship. Joe, however, presented an alternative view, appearing not to care if the therapist was an expert:

*It's important that someone understands, so when it comes to that cliché really what you want to hear is not somebody with a PhD no offence to me you or anybody else, but actually that there is somebody who actually just gets it. You know and treats you as a human being you know. (Joe, P12, L22-24)*

The notion of someone having empathic understanding is described as important for Joe, more so than certificates and qualifications. Participants also described encounters whereby therapists had been perceived as not understanding the impact of CSA, or even minimising those experiences. Jack described his experience as being disregarded as nothing, which he considered extremely unsupportive:

*I saw a psychologist actually and I told them about this and he kind of said "I don't see any, you got no issues", and I was like "it doesn't feel like that" (Jack, P15, L2-4)*

Jack illustrated the conflict between feeling like something was wrong with him, and being told by psychologist that he had no issues. His problems were minimised, yet, to Jack, his

experience was very different. Similarly, Dan felt his problems were also overlooked and trivialised:

*Yeah...just fear, stress and that's what the GP said when I told him about that, "well yeah.... soldiers shit themselves when they go over the top" ... "yeah thanks mate" (laughs) and yeah for a while, you know I do still carry Imodium wherever I go (Dan, P14, L26-28)*

Again, Dan resorts to using humour, perhaps as a defence mechanism to hide his underlying feelings. The ongoing impact of Dan's suffering is evident: he continues to suffer with physical problems relating to his earlier experiences of sexual abuse. His GP's comment is extremely insensitive and infers the notion of 'these things happen, deal with it' type of attitude, and although Dan laughs, it is clearly having a significant negative impact on his life.

In addition to therapists' statements that were considered negative or harmful, their behaviours were also discussed:

*I used to be trying to talk about my stuff, and he'd be like that (demonstrates falling asleep) and in the end, and I sat, and I put up with it. (Dave P23, L2-4)*

Dave states how he tolerated his therapist's behaviour until an opportunity arose for him to end the sessions. Despite his anger about how he was treated, it seems he was unable to be more assertive and confront the therapist about his behaviour. Reflecting on this as an adult, he reveals his own disbelief about what he put up with and how he was treated.

A significant hindering factor amongst the participants' narratives was the fact that they felt unable to talk about their experiences:

*I think without being able to talk about it you almost inevitably end up in a cycle of self-destruction of one sort or another. Because it is such a crippling.... cancer you know that if you don't let it out somewhere... it will do you in one way or another. Whether it's with your relationships with others, whether it's*

*drinking yourself to death or self harming in other ways... whether it's becoming completely reclusive... (Dave, P46, L12-16)*

Dave uses the term 'crippling cancer' when referring to the experience of keeping the abuse memories to himself, highlighting how damaging this was for him. His efforts to remain silent led to the deterioration of relationships, his physical health and contributed to psychological suffering. Also noteworthy is that he uses the term 'you' instead of 'I', perhaps to distance himself from the reality of what he has been through. Likewise, Joe talks about the 'silence' as harmful:

*I believe it's the silence that causes most of the damage. You know most survivors, when you look at abuse the physical side of it was bad... in some cases, in some cases, people weren't bothered about the physical side of it, but the emotional, the betrayal at the time was bad, but actually what really gets them is the fact that they have never been able to talk about it so they've had to live on their own with it in silence. (Joe, P23, L3-7)*

Joe feels strongly that the silence surrounding abuse does the most damage. He infers that although the physical side is bad, this aspect does not compare to the harm that remaining silent does. Perhaps Joe considers that the physical injuries heal, but the psychological issues remain, and the silence prevents any potential healing. From the first theme, it was evident that participants shared a variety of reasons for remaining silent. Another of these is illustrated by Barry, who highlights the assumption that if you have been abused, you might go on to perpetrate abuse:

*Researcher: So was that an automatic presumption? You know that you might have been a risk to others?*

*Barry: Yeah it was just because of the way the young person disclosed to me, it was in the form of a question, therefore, the young person said "you're not going to do this and that"... so therefore the assumption was made that that act was done to him, possibly by me or another member of staff. (Barry, P1, L13-17)*

Here, Barry reveals that a client's disclosure at work led to him being investigated. It seems that because of Barry's own history, the immediate presumption was that he might have abused the client. This has the potential to impact help-seeking and discourages survivors from speaking out, particularly if they work with vulnerable client groups, as Barry did.

The extracts chosen to represent this theme illustrate a variety of factors that can hinder help-seeking, including the behaviour of a therapist, the way words are spoken by therapists, being accused of being a perpetrator and the implicit notion of having to remain silent.

### **3.3      *Helpful Aspects***

Despite the hindering aspects, participants shared positive experiences of help-seeking and therapy. Participants discussed valuing the creativity provided in therapy. For a number of participants, creativity was considered to facilitate effective therapy:

*At that therapist's place there was a drum kit in the room... there was beanbags to throw and things like that... all sorts of things like that (Barry, P20, L8-10)*

Barry found the use of props and equipment helpful in enabling him to process his emotions, and in using a variety of methods, he overcame some of his anger and frustration. In the same way, Ben found creativity and flexibility in therapy essential to helping him move forward:

*He was very very human. He wasn't an expert in anything in his eyes, in fact he, he would do things like; he'd say oh who is it?...Penny Parks, "is it ok that you and me are on a learning thing together, there's a book that's been recommended, I want us both to be reading it at the same time". [...] his attitude was "never put me on a pedestal, because only thing that can happen in is I fall off", he said "you will catch me out, I will let you down, I will piss you off, I will hurt your feelings. So don't be surprised when I do those things. I will not say to you I won't do those things, in fact I promise you I will. Because I'm human." (Ben, P10, L5-15)*

Ben initially struggled with interpersonal relationships and trusting therapists; therefore, it was important for him to be able to develop a therapeutic relationship. Ben emphasises the importance of the collaborative nature of working through his difficulties with a therapist, and his perception of his therapist as 'human'. The therapist seemed to be teaching Ben about his feelings, that it is acceptable to make mistakes and invited him not to trust him until he was ready. The idea of learning together by reading a book emphasised that both were equal in the therapy room, dispelling the notion of the therapist as expert. Participants also described the benefit of social support, and of reading literature that resonated with their experiences. Feeling understood was considered to be a significant positive factor for the majority of the participants, as highlighted by Joe:

*As you read chapter after chapter you realised this man must know you, you know, not all of the things, but a lot of it. He really touched it. (Joe, P12, L17-19)*

Joe found a book on CSA he had read to be particularly inspiring, and learning that someone else understood him and the kinds of things he had been through was helpful for him. One of the specific aspects that participants identified as contributing to their ongoing recovery was talking and sharing experiences with other survivors:

*I think you know, just being, talking about this in a group setting and to be able to talk to people who have been, you know, Raul and I talked a lot about it, finding other people who have been through similar things, and willing, who were open and willing to acknowledge the truth of it...(Jack, P24, L8-11)*

Jack describes how being around other people who were open and willing to share their experiences gave him the courage to face his own; as such, he began to work on his own emotional difficulties in therapy. Dan also emphasised the benefits of social support and meeting others who had been through similar experiences:

*You know that was what I felt I needed more than having you know, highly qualified or experienced therapists or psychoanalysts I wanted to meet people who'd had similar experiences and who'd managed to find a way to deal with it. (Dan, P9, L10-13)*

Overall, social support was considered a key aspect of help-seeking. Dan captured a sense, articulated by most of the participants, that being understood and finding others who shared similar experiences, and having opportunities to find out how others coped, was considered to be a helpful factor, over and above having an overly qualified therapist. This illustrated the concept of having an equal, perhaps someone who is just like you, who might better understand what you are going through.

A key aspect, considered to be beneficial by participants, was having the opportunity to connect with the emotions repressed during childhood, as Jack illustrates:

*It seemed to be one of the key things of doing the therapy was to try and connect with those, all those raw emotions from infant level that had been suppressed and I began to realise that, you know I just wasn't allowed to experience that you know I just wasn't allowed to express them from age zip.*  
(Jack, P13, L17-20)

Jack illustrates how his upbringing perhaps contributed to his emotional inexpressiveness. He identified the need to process the emotions he had suppressed, and shared the importance of having the freedom in therapy to explore and connect with these emotions, because he was not allowed to show them during his childhood. It could be hypothesised that the safety of a therapeutic environment facilitated this process.

Other participants also recounted similar experiences of gaining understanding about their difficulties. One of the key things highlighted was the experience of finally learning and believing that they were not at fault for having been sexually abused:

*The things that were said to me all those years ago about it not being your fault and I think they are very simple things, but I think they are profound and totally essential to helping people to move on because... most or many survivors of abuse and again... I'm speaking for myself, I know, we really do believe we were responsible in some way for what happened to us.* (Dave, P34, L4-8)

Talking about the positive aspects, Dave shares his advice regarding the key things he found instrumental in helping him re-think his perception of himself as being at fault. He illustrated how essential hearing the words 'it's not your fault' can be for a survivor of sexual abuse, sharing how he felt responsible for his abuse and therefore how he needed to feel and believe that he was not at fault.

Participants shared that particular techniques were employed to illustrate certain points, for example, the metaphor of *The Lion King* was used to demonstrate to survivors how powerless they were as children:

*He did this presentation and it was using, this is cos it sticks in my mind... it was using the Lion King... and a way in which the baddy in the Lion King is it Mufassa, subjugates and dominates the little lion cub and it was quite clever the way he did it of equating that to the grooming process, to the manipulation, to passing the responsibility for what happened to the dad, to the little cub... [...] he said "imagine you're sat where you are now in this seminar room in this university in [...] and imagine a man walks in now and he's nine foot tall and he comes and grabs you – what are you going to do about it? That's exactly what happens to the child because you are a child this big and the adult is a giant... you have no power or control over that at all" and again something as simple as that I thought just really powerful. (Dave, P35-36, L28-29 & 1-9)*

It is evident by his recollection of this detailed intervention that it remained with Dave; therefore, the usefulness of such techniques is illustrated. It also highlights the potential to help individuals challenge their thinking on issues such as blame, power and control, and the helplessness of a child experiencing sexual abuse.

Participants highlighted a variety of factors that have helped and hindered their progress in their help-seeking journey. The theme below follows on from this, sharing how participants made sense of what had happened to them as adults, and how this helped them move forward in their lives.



#### **4. Master Theme Four: Continuing the Journey - Making Sense and Moving Forwards**

The theme 'Continuing the Journey - Making Sense and Moving Forwards' illustrated the meaning-making aspects of the participants' journeys and described the ways they found of making sense of their pasts, in order to move forward with their lives. The theme name 'Continuing the Journey' was used to emphasise the recovery process and how participants moved forward, and in doing so, understanding and overcoming some of the difficulties relating to their past experiences of childhood sexual abuse. Participants spoke of changes they had identified in comparison to their earlier years, some with reference to therapy, others with reference to getting older and being able to see things more clearly, for example, their own behaviours, which, although helpful at the time, were later considered destructive. Making sense and moving forward consisted of the following sub-themes: 'Making Sense of the Past', 'Wounded Healers' and 'Recovery as an Ongoing Process'. These are discussed in the relevant sections below.

##### **4.1 Making Sense of the Past**

In the following sub-theme, 'Making Sense of the Past', participants discussed how they gained understanding about their past experiences, which enabled the identification of on-going difficulties associated with CSA. In learning about CSA, participants were able to apply new information to their own experiences and thus work on their recovery.

Participants appeared to continue to make sense of their pasts whilst engaging in the interviews. The example below by Joe illustrates this process as he talks to me about a therapist who, in the past, made him feel as though it was him who had done something bad:

*You know looking back it's almost... "what do you mean by I don't want to hear anything that's going to be bad", and all I'd said is "I was sexually abused in, in childhood", you know nearly 20 years on one starts to reflect and think what did she think I was going to say? That I'd abused people you know. (Joe, P3, L2-5)*

In a similar way, Dave said:

*You know, it's taken me many, many, many years to try and process what kind of went on in those days. (Dave, P4, L16-17)*

Both excerpts highlight the length of time it took Joe and Dave to process certain aspects of what had happened to them. Joe specifically refers to the assumption that he might have gone on to abuse others, and how only years later did he realise this. In contrast to describing the length of time it took to make sense of his difficulties, Sam implies that now he is older, he is able to rationalise and see things more clearly:

*Just to get it out, you know, cathartic, just to get shot of it and try and make some sense of it... now I'm older I can rationalise. When I was younger I couldn't. (Sam, P1, L18-20)*

Jack described a similar experience to Sam, identifying that years later he was able to make more sense of his behaviours. He also illustrates how the repercussions of CSA filtered into other aspects of his life:

*I was carrying it for all those years and somehow blamed myself that I'd done something wrong and just the realisation that... and I think that did filter through into my sex life, intimate relationships because I was carrying this guilt and that somehow this sex was shameful. I think a lot of that was brought out into the open and looked at and you know re-processed um, I think you know I think the Catholic guilt thing is also mixed up in that. (Jack, P22, L17-22)*

In sharing the above, Jack emphasises how the CSA can entail ongoing consequences and pervade interpersonal relationships. Furthermore, certain factors, such as his 'Catholic guilt', appeared to exacerbate his symptoms, contributing to the shame he felt. Jack illustrates how he came to understand these things about himself, and was then able to re-process his thoughts and emotions. Ben also provided an example of making sense, in learning that he hadn't gone mad, and that his behaviour and coping mechanisms would have been considered as understandable, considering the abuse he went through as a child. He states:

*It's not only me this kind of shit happens to.... But I'm not mad.... The way that I've dealt with it, the things that I've done, the belief systems that I've built up...I ok... this in itself isn't gonna fix items. But at least I know I'm not mad,*

*I'm not a complete bloody loony, and I'm not beyond help. So that kind of restored some kind of faith and hope that things can be different. (Ben, P12, L20-24)*

Learning about and accepting his behaviour enabled Ben to make sense of why he acted in the ways he did. The process of him changing his views of himself as 'mad', and the realisation that he is able to consider that he can access help and move forward, is evident. He is positive about change, as illustrated by his comment 'I'm not beyond help', and he shares his faith that things can be different for him in the future. He later gave a further account of how he embarked on a process of change, integrating his buried emotions into his current life:

*It's that acceptance of.... yeah maybe that was actually the biggest part of it was... learning that even... dealing with it now, you, it's a different thing because you are looking back and you are reflecting.... but there is still the emotion of it to deal with which is entirely separate and buried at a different kind of level and looking at things and talking about things, from the completely detached point of view, can be largely irrelevant because, all I can say is my experience, I don't think by far, or I won't do it as a generalisation, is having learnt to do that whole dissociation thing, well actually I went through the stuff without emotions so there is no point in trying to deal with it without emotions. Because actually they are the two completely separate incidents in fact the only time when things started to make a difference was when dealing with it on and emotions and an acceptance level. (Ben, P17, L42-51)*

In being aware of these issues, Ben realised his ability to work through them. He described the different levels of processing involved for him, and how he compartmentalised or separated his emotions from his behaviour, detaching from his experiences. Thus, looking back as an adult, although perhaps he is still largely detached from his emotions, he can see that there may be a need to begin to process what happened to him by exploring his emotions further.

Sam shared his understanding about how he acts and engages with others, and what he has learnt about himself:

*I try and avoid confrontation with people because I do have a tendency to... I know I've been reading about it and now I understand it. I have a tendency to overreact to... to personal threats and things like that. If I feel I guess it's going back to that. If I feel I am going to be hurt or... now even maybe erm psychologically hurt, you know emotionally hurt, I tend to overreact, push people away you know. But I know I've got this problem so I am working on dealing with it you know. (Sam, P2, L33-34 & P3, L1-4)*

In an attempt to understand his behaviour, Sam described how he had been reading up on things to further his understanding. He identified that he struggled with certain things, such as confrontation, and his realisation of the problem has helped him begin to work on it in his own ways. He elaborated on how reaching a certain age and becoming more knowledgeable helped him to understand his experiences in a new light:

*Erm... you come of age, and that is where I know what happened was not my fault, I wasn't doing... I didn't do anything wrong. (Sam, P3, L11-12)*

Sam illustrated a theme shared by all of the participants, the notion of letting go of the blame and the conception that the abuse experience was in some way their fault. He identified the importance of acknowledging that sexual abuse was not his fault. Coming to learn this was hugely significant in his recovery journey. Dave shared a similar experience:

*I think back to that stupid woman in [...] saying "I don't know why you didn't stop it" and I was seven and probably weighed three stone or something, and he was a rugby playing thirty two year old.... yeah, how the hell could I stop that. (Dave, P36, L10-13).*

He refers back to the words of the therapist who questioned him about why he didn't stop the abuse occurring, illustrating his feelings and the profound impact this statement had on him.

Despite gaining some understanding through various methods, participants reported that they continued to have difficulties in some areas of their lives. Dan described that the physical and somatic symptoms continue to have an impact for him:

*I suppose I get by alright, I suppose it's the physical stuff, my bums never been right, my intestines are, they are really kind of knotted and nervous, that physical discomfort which isn't any way near as bad as it was but when it was bad it was awful. Rotten teeth, sticking needles in my arms all that basic physical integrity and self-respect on a physical level, and you know I was happy to sit, you know wrapped up in a blanket with a sign in front of me saying "give me some money", you know and id go and buy heroin and stick it up my arm, veins. That level of self-disruption...was just err... and wanting to be, you know wanting to just destroy myself. That was err; I suppose the hardest place I've been. (Dan, P24, L9-18)*

Although he feels that he is now doing much better, he recounted the hardest things he had been through, and the ongoing difficulties he experiences. He shared how the turmoil inside himself led him to seek desperate measures in an attempt to stop the emotional and physical pain he was experiencing as a result of being abused, and how he engaged in a form of self-sabotage to escape his memories.

#### **4.2 Wounded Healers**

The term 'Wounded Healer', originally described by Carl Jung as an archetype, originated with the Greek myth of Chiron, who was physically wounded and, by way of overcoming the pain of his own wounds, became a teacher of healing (Etherington, 2008). The view that a healer's own wounds can help others is paramount and embedded in the narratives of the participants in this research. The theme has emerged from two angles: firstly, the experiences encountered with other wounded healers during the process of help-seeking; and, secondly, taking control and becoming a wounded healer themselves due to lack of appropriate resources. Several of the participants described being unable to find appropriate support and have either become involved in delivering services to survivors, or described planning to do so in the future.

The potential for wounded healers to cause damage was illustrated by Joe. Joe attended an assessment session with a therapist who he considered did not contain his distress and left him feeling re-traumatised. He later found out that she had been attacked by a male survivor of sexual abuse some months prior to meeting him and had only just returned to work:

*She'd gone through this assessment where effectively she projected her own fears on to me that I was potentially dangerous, I was actually going to kill people and all this type of stuff, and all I'd done was basically I'd disclosed my abuse history, so you have, again there I went through massive issues. (Joe, P5, L22-24)*

Joe experienced further trauma after disclosing, and it is apparent that the therapist also experienced significant distress. This illustrated the importance of the therapist's self-care and ensuring they are able to maintain personal and professional boundaries in relation to their own traumas and difficulties. As Dan highlights, many survivors go in to working in areas where they are required to help others. He became a volunteer in a service that supports survivors of CSA, and described his awareness of the dynamics of working with others who have experienced similar issues:

*I wouldn't complain about other people being messed up because I'm totally messed up, but there are a lot of people round here who have got issues themselves and I don't think that's too good a match because you know there is kind of a lot of unresolved stuff... (Dan, P16, L16-18)*

Although he considers himself as messed up, he appears to have a level of self-awareness. Similar to Dan, Joe also began supporting other survivors of sexual abuse, identifying himself as a wounded healer. He elaborates on his reasons for choosing this type of work:

*You quickly realise you have to do it for yourself and you know a lot of us become collectivised to political action and that's why I did really because I decided that, I was quite ang... I was annoyed, very angry, not that raging angry but there was actually no services. I found it shocking, and I still find it shocking. (Joe, P10, L7-9)*

The lack of support available led several participants to embark on either paid or voluntary work with survivors of sexual abuse. Others talked of starting or planning to start their own groups, implying that they had no choice but to do things for themselves:

*I have been asking around tentatively about a room... I may or may not; I'll have to see how I get on over the next three to six weeks, start delving into actually starting a survivors group in my own town. (Barry, P28, L13-14)*

Participants appeared to gain strength from helping others; however, as Dave illustrates, this was perhaps an unconscious or conscious way of avoiding their own recovery:

*That became a focus... completely and also to the exclusion of getting help for me of course, which is why fifteen years later I'm back in therapy again trying to sort out the mess that's still up here from my childhood and everything. Erm so yes I kind of put my recovery if you like on hold for the next few years... (Dave, P22, L22-25)*

Having something to focus on helped Dave to cope in the initial stages when he could not find help for himself. Perhaps Dave did this as a way of avoiding dealing with his own difficulties. He now actively campaigns for more support for survivors, whilst also finding time to work on his own problems.

#### **4.3 Recovery as an Ongoing Process**

The final sub-theme encapsulates the idea that, for survivors, the process of recovery is ongoing. Progress is not made in linear stages, but is made at different times during one's lifetime. One participant talked of recovery in terms of measuring progress and reducing particular symptoms, whereas others talked in broader terms about how they had come to make sense through therapy or their previous experiences. It was evident that all of the participants had been through their own individual journeys, and their experiences of coping and adjusting to life prompted them to want to share their experiences for this study.

The concept of measuring targets for recovery, and aiming to achieve symptom remission, was illustrated by Dan:

*That was my first target, trying to get to a point where the nightmares stopped. (Dan, P8, L12-13)*

Setting targets (i.e. stop the nightmares) implies, perhaps, that Dan wants to be cured. It is possible that setting goals to work towards appears to keep him focused on his recovery journey. Dave, however, rejects the idea of a 'cure', and instead refers to recovery as 'on-going':

*It seems like it's an on-going effort, I think maybe with many survivors that they think that there is a quick cure and there isn't that no, it's an on-going recovery process... (Dave, P31, L24-26)*

His reference to 'many survivors' and their assumption of a 'quick cure' suggests Dave has experience of the opposite. In fact, he states, recovery requires ongoing work and effort, which is perhaps not the expectation others anticipate. Reflecting back on his own recovery, Dave was explicit in embracing his own accomplishments:

*There are still times when I feel a complete failure but they are lessening... significantly now, and I'm starting to think, yeah, I've done bloody well actually, this is good you know. (Dave, P33, L25-27)*

He indicates that, despite occasions in which he reverts to feeling 'a complete failure', he is able to look back and acknowledge how far he has come. Like Dan, he associates his improvement with his symptoms lessening significantly, as if also measuring his progress. Dan's perspective illustrates a similar feeling of looking back on the past and the realisation of the positive changes in his life:

*I look back to where I was and I'm a different person and the people that have known me for a long time can see that but um... still far from where I wanted to get to. I suppose in terms of just sort of everyday balance you know. (Dan, P15, L23-25)*



His quote also illustrates his strive for continuing his progress by his words 'still far from where I want to go', demonstrating his motivation and perseverance. This is further illustrated below:

*I do figure it's do-able... I don't quite know how. I've got a kind of broad optimism, again that's from the literature, from the work that I've seen, from people who have made progress and got to a sort of, you know, a place of sort of relative stability. I believe in it... I think there's an awful lot of different routes through it... (Dan, P16, L27-30)*

Dan illustrates an element of hope that he can achieve his goals, and it is possible that his past experiences have generated resilience. Furthermore, the idea that it can be done, and that one can make progress and live a stable and comfortable life, becomes a possibility and contributes to his beliefs about making changes and moving forwards in his life.

Like Dan, a number of participants discussed the different routes of help-seeking, engaging in different types of therapy and at different times in their lives. Most stated they would or had gone back to a therapist if a different problem in their life arose. Ben, who appeared positive about his progress, described:

*Every now and then, when I have, when I sort of like had that first kind of like attempt at a relationship. I did go back, and I saw the same guy, Jack, for probably about another ten or twelve sessions, and if certain key things come up I will happily go back again. (Ben, P16, L22-24)*

*The main thing is stuff is changing, I'm trying different things and it's doing different things... errrr challenging meself in different ways, and then if I then struggle with the repercussions I know there is a support network there if want to take it up. (Ben, P17, L12-14)*

By acknowledging that recovery is ongoing, participants have the freedom to make mistakes and learn from them and to return to therapy if needed. Ben evidently feels comfortable with Jack (his therapist) and they have developed a relationship within which he is able to explore the various impacts and psychological repercussions that may occur in his life as a result of

being sexually abused in his childhood. The 'key things' Ben refers to are connected with starting new relationships, and the notion of love and trust, which whilst growing up he had associated with abuse and violation. His second quote illustrates the positive changes that have occurred and the changes he has made ('trying different things'); at the same time, he is aware that he has built up a support network that is there if he needs it.

A number of other participants demonstrated a similar commitment to recovery by describing the use of the various interventions and forms of psychological therapy they have tried and would be willing to try in the future. On the other hand, this could be considered as an attempt to find a form of therapy that works. When asked about the concept of recovery, Sam shared his perspective:

*I don't think... I mean people will say they have... it's there, it's all locked away and wrapped up and they haven't gotten over it they've just hid it you know. (Sam, P9, L12-14)*

Sam illustrates his scepticism with the notion of fully recovering from CSA, inferring that what people say and the reality are very different. Perhaps he is referring to himself when stating 'they haven't got over it, they've just hid it'. Showing his own courage, and his intention to help others, he states:

*I'm proud of meself for having the balls to tell everybody now what went on. And I'm even proud of telling you because this is another step you know, and I think it's a step that will hopefully help somebody else. (Sam, P8, L1-2)*

Sam spoke of the benefit in taking part in this research and his hopes to help others by sharing his story. For him, this experience was considered a highlight in his own unique recovery journey and, indeed, others shared a similar perspective.

Overall, theme 4 illustrates participants' reflections on their experiences of help-seeking and the challenges they faced in making sense of the difficulties associated with CSA. It is evident that opportunities for making sense of their difficulties facilitated the challenging of previously held negative beliefs about themselves and their role in the abuse occurring.

Participants also examined ways in which they conceptualise their recovery and continue to manage the psychological repercussions of having been sexually abused in childhood.

### **Summary**

To summarise, this chapter has brought together the findings of seven male participants who embarked on the journey of sharing their experiences with me, revealing four master themes: 'Disclosure', 'Searching for help', 'The help-Seeking Journey', and 'Continuing the Journey - Making Sense and Moving Forwards'. The quotations and extracts selected illustrate the devastating impact CSA can have on a survivor.

The first master theme, 'Disclosure', shared the experiences pre-, during and post-disclosure and reveals how complex this process can be for a survivor of CSA. The second master theme, 'Searching for Help', explores the process of beginning to seek help as a male survivor, and some of the issues that arose during the interviews when sharing their stories. This theme illustrated the dilemmas that surround help-seeking, particularly for men who also have to contend with stigma, social attitudes and gender issues. 'The Help-Seeking Journey' captures how each participant embarked on a unique process of healing, suggesting that survivors need to find a method of healing that works for them and supports their needs. The final theme, 'Continuing the Journey - Making Sense and Moving Forwards', illustrated how making sense is an integral part of the acceptance and healing process, and although the notion of recovery was considered as ongoing, participants remained hopeful about their future.

In the sharing of their stories, all participants described the challenges they faced in overcoming the repercussions of CSA, and the complexities of accessing support and therapeutic intervention. For Sam, who had previously never spoken to anyone about his abuse, this was particularly significant. Also of interest was the way in which participants communicated their emotions through their narratives, from the masking of frustration and despair with humour, to the use of sarcasm. In the following chapter, the themes identified are discussed in more detail, with reference to existing theoretical literature.

## **Chapter 4: Discussion**

### **Outline of Chapter**

The previous chapter has described the four master themes and associated sub-themes identified during the analysis. The aim of the following chapter is to review and critically discuss the themes with reference to existing research, adding to and expanding on the literature presented in the introduction to incorporate the emergence of new findings. Phenomenological research aims to present shared as well as idiosyncratic experiences (Ashworth, 2008), and whilst each male's experiences are unique and pertinent to their own lives, the themes embedded in their narratives revealed both shared and idiosyncratic experiences. The immediate and overriding consensus across the accounts was of negative experiences of seeking help. All participants were at various stages of recovery and each male was negotiating his individual journey and personal healing process. The aspects revealed through the process of analysis are explored in the context of the existing literature below. Whilst the master themes are presented as distinct, there is overlap between and within them. The following section discusses the themes with relevance to the existing literature, and considers implications for theory and practice. To conclude, the chapter will discuss the strengths and limitations of the study before suggesting areas for future research.

### **Master Theme One: Disclosure**

The four sub-themes presented within the master theme of 'Disclosure' captured the multiple dynamics and complexities involved in the process of disclosure illustrating the experiences pre-, during and post-disclosure, as described in the men's accounts. The notion of keeping the abuse a secret was embedded in the participants' narratives and was a pivotal reason for lack of or delayed disclosure; however, as adults, remaining silent was described as damaging. The act of disclosure was considered a key aspect of help-seeking; nonetheless, as illustrated from the quotes, many factors either helped or hindered this process. Disclosure, for the majority of the participants, helped to begin the process towards seeking help, and despite the challenges, led to positive outcomes and change.

Existing literature has sought to understand the process of disclosure in both male and female survivors of CSA; however, as Alaggia, (2010) notes, barriers and facilitators of disclosure are still not that well understood. Herman (1992) and Summit (1983) both noted that children rarely tell anyone if they have been sexually abused; nevertheless, these

findings have been criticised with regard to methodological issues due to the problematic use of the term 'disclosure'. Importantly, there is a lack of clarity as to whether the term 'disclosure' refers to the act of simply telling someone, or to a more official act of reporting abuse to an authoritative body. In the current study, disclosure is conceptualised as conveying or attempting to convey the experiences of abuse to another person (Jones, 2000); thus, the focus of this master theme is about the telling or not telling about the experience of being sexually abused. Several participants made attempts to disclose during childhood, but these were unsuccessful, dismissed or trivialised, and only three of the seven males had reported the abuse to the police. Interwoven through the participants' accounts appeared a sense of an internal struggle which entailed confusion and uncertainty about the disclosure process. Furthermore, the implicit view that one had to remain silent was evident through the ambivalence in participants' accounts about speaking out. The lack of disclosure amongst the participants was consistent with findings by London et al. (2005), who stated that many children simply do not disclose sexual abuse. As such, the challenges of life pre-disclosure included the need to remain silent for all of the participants. For some of the men, the abuse experience appeared to be overwhelming to the point where they cut off completely and created new identities and new lives. In order to do so, several described detaching or dissociating from their experiences using a variety of strategies, which appeared to be a form of protection from the physical, emotional and psychological impact of CSA. Detaching refers to cutting off or separating oneself from the memories and experiences that caused emotional and physical pain. Dissociation is considered to be a complex psycho-physiological process that creates various defences across the domains of the self (Putnam, 2001). Marx, Calhoun, Wilson and Meyerson, (2001) explain that survivors might attempt to ameliorate the negative emotions such as shame that manifest in adolescence and persist into adulthood through the use of alcohol or substance misuse, or self-regulation through the spontaneous use of dissociation. Ben, Dave and Dan shared their experiences of using drugs or alcohol to escape from reality, providing support for this theory.

Delayed disclosure is a common occurrence (Alaggia, 2004), with findings from research suggesting that an alarming number of children and adolescents (between 60–80%) delay disclosing until adulthood (Alaggia, 2010). Studies examining the delay between sexual abuse and disclosure (latency to disclose) report delays from 3 to 18 years (Hébert et al., 2009; Lamb & Edgar-Smith, 1994). Consistent with these findings, the majority of the participants in the current study delayed disclosure for 10-15 years.

There are a number of theories within the literature that offer plausible explanations for the lack of disclosure in male survivors. Such theories offer insight and help to account for the experiences of the men in this study. Summit (1983) introduced the Child Sexual Abuse Accommodation Syndrome, a theory that proposes children's responses to child sexual abuse comprise five stages: 1) secrecy; 2) helplessness; 3) entrapment and accommodation; 4) delayed, unconvincing disclosure; and 5) recantation. These stages are discussed further in the introduction section, however, briefly, secrecy refers to the implicit need to keep the abuse a secret. Helplessness reflects the vulnerability of a child who is abused by a trusted adult, often in the context of a care-taking role. Entrapment and accommodation refers to the notion of being unable to escape, and therefore the child puts up with the abuse. Delayed, unconvincing disclosure emphasises attempts made by the child to disclose, which may then be retracted (recantation). Summit (1983) proposes that sexually abused children's disclosures are delayed and inconsistent because of these dynamics of sexual abuse. This theory has been supported by research findings (Elliot & Briere, 1994; Faller, 1988; Lawson & Chaffin 1992; Sorenson & Snow, 1991). However, Alaggia (2004) argues that there is little empirical follow-up. Several authors emphasise that one must be aware of the literature that criticises accommodation and dispute that accommodation is based on anecdote and not rigorous scientific evidence (Bradley & Wood, 1996; London, Bruck, Ceci & Shuman, 2005). Nevertheless, the participants in the current study revealed several aspects which could be considered consistent with the stages in Summit's model: few had disclosed as children and felt the need to remain silent about the experience of sexual abuse. Several explicitly stated that there was nothing they could do at the time due to being powerless and vulnerable; therefore, they had to put up with it. Some participants attempted to tell others about the abuse during their teens, yet such disclosures were either minimised or dismissed.

The difficulties with disclosure amongst participants' narratives are consistent with Draucker and Martsof's (2008) theoretical framework that described how survivors of CSA tell others about their abuse experiences. Their initial theme 'Starting the Story: The Story-Not-Yet-Told' is similar to the sub-theme in the current study of 'Pre-Disclosure - Dissociation, Detaching and Distancing' whereby participants described being aware of their experiences but unable to speak out, and actively avoiding, denying or dissociating from their past experiences to cope.

According to Spiegel (2003), the majority of sexually abused boys and men do not disclose sexual abuse due to the fear of negative consequences. This is relevant for the participants in

the current study, whose narratives revealed internal conflicts between wanting to speak out and being unable to for various reasons. Dan and Dave spoke specifically about wanting to protect their family members from knowing what had happened to them. Similar findings have been described in existing research (Alaggia, 2004; Draucker & Marsolf, 2008; London et al., 2005; O’Leary & Barber, 2008; Ullman, 2003). In contrast, Ben attempted to tell his parents; however, they showed no interest in hearing what had happened to him, possibly due to the fact that his abuser was his brother. Alaggia and Millington (2008) found that participants’ stories of sexual abuse were not always believed or taken seriously. Similar findings were reported in the current study, with participants’ attempts to disclose receiving insensitive and even harmful responses, including their accounts being minimised or dismissed entirely.

As adults, the participants in the current study appeared to reflect back on the reasons for their lack of disclosure. Durham (2003) proposes that deciding to keep sexual abuse a secret appears to be ‘...inextricably bound up with the messages the child receives from the adult during the abuse itself’ (p. 81). Dan described being told by his perpetrator not to tell, which was further reinforced by his mother’s disbelief upon his disclosure. Dave and Sam reflected on the implicit message of keeping quiet because they felt they were to blame for the abuse occurring. This belief was further reinforced by the perpetrators of the abuse. Several of the participants described feeling isolated, sharing the thought ‘I must be the only one this has happened to’, which prevented them from disclosing. This is consistent with findings from the existing literature. Hunter (1990) found that sexually abused males frequently suffer from the isolating effects of believing they are the only one to have ever been abused.

Participants also described not making the connection between their abuse experiences and their current difficulties, with a number of them finding it hard to understand how something that happened in their childhood could continue to impact them in certain ways in adulthood. Hunter (2011) expands on this by discussing the difficulties survivors have in defining sexual abuse, such the age of the victim at the time of the abuse and the level of coercion involved. He postulates how difficult it is to acknowledge any type of child abuse, let alone child sexual abuse, particularly if the child is unaware of what is happening to them. This has implications for professionals working with survivors who might be unable to articulate what happened to them, or link the experience to that of being sexually abused. Dave, for example, described never making the link between his past abuse and later problems with substance abuse, low self-esteem and relationship difficulties. A number of multifaceted theories have been put

forward to help explain the long-term impact of CSA, which might help explain these findings. The Traumagenic Dynamic Model (Finkelhor & Browne, 1985), for example, highlights how the consequences of CSA impact on different aspects of psychological functioning. Furthermore, one of the frequently discussed impacts of CSA appears to be an inability to manage emotions, thus impacting an individual's capacity to control or tolerate strong (especially negative) affect without resorting to avoidance strategies such as dissociation or substance abuse (Briere, 1992). This might explain participants' experiences and account for why over half reported problems with substance misuse and addiction.

Briere (2002) further expands on the impact of CSA on adult psychological functioning, reporting that one of the earliest impacts of abuse is thought to be on the child's internal representation of the self and other. Traumatic early experiences with trusted adults lead a child to develop negative inferences about themselves, the world and others. Consequently, the child may come to view others as inherently dangerous and untrustworthy, rejecting or unavailable. The impact this can have on later life is that individuals find it difficult to change such perceptions and they become ingrained in their personality or sense of self. The quality and valence of these core schemas intrinsically affects the individual's capacity to form and maintain meaningful attachments with other people. A number of participants in the current study reported difficulties with trust and developing interpersonal relationships, which can be understood by considering the literature by Briere (2002). Further support for this is provided by Pearlman and Saakvitne (1995), who propose that trauma during the early years can result in chronic negative expectations and perceptions around issues of safety, trust, esteem, intimacy and control. All of these were embedded in participants' accounts.

All of the participants commented on the stigma surrounding male CSA and how this impacted disclosure. Gonsiorek et al. (1994) described the myths associated with male CSA, including: 'you cannot make a man have sex against their will', 'if a male has an erection and ejaculates, he consented', 'erections equal pleasure', 'if abused by a male, the abuse occurred because the boy is, or acted gay', 'if forced by a female into being sexual, the boy should consider himself lucky'. These myths surrounding CSA have been found to influence professionals' responses, attitudes and reactions to disclosures in existing research (Cromer & Goldsmith, 2010) and perpetuate notions of blame in a number of ways. Specifically, they are often reinforced by the perpetrator as a means to encourage silence. In addition, they promote unfavourable responses to the disclosure of abuse, which can culminate in self-blame, powerlessness and social isolation, as found amongst the participants' narratives in



the current study. The myth 'if forced or tricked by a female into being sexual, the boy should consider himself lucky' resonated with Ben, who was abused by both his brother and his brother's girlfriend. He described that being abused by a female had impacted his ability to develop interpersonal relationships with women. Hunter (2006) points out the contradiction that the victims of abuse are the ones who have a sense that there is something wrong with them. Since the feeling of shame is related to a person's self and not merely to an experience, the shame becomes part of the victim's identity and follows him into adulthood, affecting his view of himself. Thus, the victim often assumes that everyone somehow knows that he has been abused, is dirty or is a 'pervert' (Hunter, 2006). Dan described his awareness of the myths associated with male CSA, and the subsequent impact for him of speaking out about his abuse and being labelled 'a paedo'. This was considered to be a distinct factor associated with male CSA. Sharpe et al. (2001) found that men feared they might be stigmatised as abusers or, worse still, discover their own potential to become abusers. This resonates with findings from the current study. Participants shared their fears about others thinking they might have gone on to perpetrate abuse, which was considered another significant barrier which contributed to their lack of disclosure.

The emergence in the men's narratives of a sense of disparity between themselves as a man, and how they perceived a man should be, reverberates with discussions about the role of men in society. Many of the participants held traditional views about expressing their emotions and being seen as weak and therefore did not disclose that they had been abused. This emotional inexpressiveness can have negative consequences for men (Englar-Carlson & Stevens, 2006) and prevent them from expressing what might be considered feminine traits. This resonates with the assumptions highlighted by Dorais (2002) that 'a 'real man' would not allow himself to be dependent, vulnerable, weak or passive (p. 17). Kia-Keating et al. (2005) reported similar findings, describing that when some men experience early victimisation or abuse, they are torn between their desire to accept traditional masculine roles and the risk of being labelled effeminate if they reveal that they have been abused, and as a result, are less likely to disclose their experience of CSA to others. Men may assume that to disclose sexual abuse would lead to stigmatisation (Yarrow & Churchill, 2009); thus, keeping quiet is rationalised as a way of looking after oneself. White and Johnson (2000) and Wilhelm (2009) suggested this fits with the gender socialisation men receive growing up, to put up with discomfort and wait until difficulties impact on day-to-day functioning before acting. The findings from the current study support this finding, in that the majority of the males did not seek help until a crisis point in their lives, either following a death in the family, relationship

difficulties or an emotional breakdown. Feiring, Taska and Lewis (2002) state that a disclosure that is met with a dismissive, disbelieving, unsupportive or hostile response can be traumatic and exacerbate long-term mental health problems (e.g. anxiety, depression). Indeed, participants shared the detrimental impact of disclosing to a family member or health professional who had minimised or trivialised their account and the ways in which this contributed to re-traumatisation, anger and suicidal feelings, and further reinforced the participants' negative beliefs and perceptions about their role in the abuse.

Another significant factor highlighted by the participants as a barrier to disclosing was the stigma surrounding the concept of male CSA. Gonsiorek et al. (1994) propose that the lack of realistic images in the media prevents males from having models with which they can identify and thus feel less alone. Considering ways to reduce the stigma, Gonsiorek et al. (1994) suggest that males need to be exposed to the stories of others who have experienced sexual violence, which may result in a movement towards disclosure through the idea of possible acceptance. Dorahi and Clearwater (2012) expand on this and propose that in seeking to better understand and address men's limited disclosure and help-seeking, we are required to look beyond the stigma associated with sexual abuse itself and the 'silencing' effects of fear, confusion and shame. It is possible that the media plays a role in the non-disclosure of so many male CSA cases and could therefore be used as a medium to challenge the socialisation of boys, encouraging the questioning and challenging of limiting gender roles (de Visser & McDonnell, 2013). Media could also be utilised as a medium to educate parents, teachers and others on the subject of male CSA so that early disclosures are better responded to.

Both Draucker et al. (2011) and Chouliara, Karatzias and Gullone (2013) have proposed frameworks for recovery for survivors of CSA which emphasise the importance of disclosure. In addition, the therapeutic significance of telling one's story has also been documented by Frank (1995). Participants in the current study revealed that their disclosures in therapy were not always supported or responded to in a therapeutic way. Consequently, the assumption that children will benefit by telling someone about their abuse (Alaggia & Kirshenbaum, 2005) can be criticised. Participants described the negative and traumatic experiences of their disclosures, which, in several cases, led to years of remaining silent until adulthood. The shocking responses of professionals in relation to initial disclosures and the impact this had on subsequent disclosures, help-seeking and the ability to develop trusting relationships with others in adulthood was illustrated by Dave, Joe and Dan. Existing research has found similar findings. Holmes et al. (1997) and Ullman and Filipas (2005), for example, found that even if

sexual abuse has similar psychological effects on men and women, responses to disclosure appear to vary according to gender, with men less likely to be believed than females when disclosing to health professionals.

The findings from the theme 'Disclosure' resonate with existing research that suggests disclosure is considered an ongoing process, rather than a single event (Alaggia, 2010; Sorensen & Snow, 1991; Summit, 1983), determined by an interplay of factors related to child characteristics, family environment, community influences and cultural and societal attitudes. It is clear that rather than always being beneficial, disclosure is an evolving and complex phenomenon (Ullman, 2003; Ullman et al., 2010). These findings have implications for Counselling Psychologists who may encounter male survivors in their work. By the time a survivor decides to disclose in therapy, they may have experienced a number of unsupportive or even harmful disclosure experiences, as the findings from this study have illustrated. Therefore, it is important to be aware of the impact of previous negative experiences and how these might impact on the engagement and development of trust in a therapeutic setting.

### **Master-Theme Two: Searching**

The theme 'Searching' captures the participants' experiences of trying to find help and support. The sub-theme 'It's like a Desert Out There' illustrated how the lack of support and resources available impacted help-seeking. The sub-theme 'Being Male' described issues pertaining to gender and masculinity in searching for help.

Research exploring how men access and engage in support services is limited. In the current study, the participants revealed the challenges they faced in searching for support and how this impacted them at a time when they needed and wanted help. As described by one of the participants, 'it's like a desert out there', in terms of services that offer support to men. All of the participants described their disappointment in the limited support they initially received from health professionals. Consequently, several took action and developed their own support networks and services. In describing the experiences of searching for counselling, participants revealed that their General Practitioners (GPs) were unhelpful and unaware of local support options. Dave and Dan spoke about their fruitless visits to their GPs and subsequent experiences of searching for private therapy. Three of the participants reported their abuse to the police; however, only one described this process in detail. Consistent with existing research, men are unlikely to report sexual abuse to the police (Pino & Meier, 1999).

The lack of support services is illuminated both by participants in the current study and in existing research. Chouliara et al. (2012) carried out a systematic review summarising and evaluating counselling and psychotherapy provision for CSA from survivors' perspectives. Out of nine reviewed studies, only two were UK-based, both unpublished, one utilising a female-only sample (Nelson, 2001) and the other a male-only sample (Nelson, 2009). The findings from this review emphasise the lack of research exploring survivors' perspectives of services, particularly in the UK, with the authors concluding that research on survivors' perspectives of treatment effectiveness is limited and characterised by methodological limitations, including poorly described samples, selection bias and a lack of information on treatment approaches (Chouliara et al., 2012).

Despite the view that professional intervention is an effective and important factor in the recovery of CSA, many male survivors fail to receive treatment (Tingus et al., 1996; Warne & McAndrew, 2005). Similar findings were reported in the current study; participants visited their General Practitioners to enquire about support and counselling services at different times as adults and were dissatisfied with the outcome. Several described being initially offered anti-depressants, which was considered unhelpful. Subsequent visits and persistence led to participants being offered six sessions of counselling provided by the National Health Service; however, again, this was considered as insufficient and possibly even detrimental for a survivor of CSA. As Joe describes, the perception that one will be fine after six sessions can leave men feeling like a failure if therapy is unsuccessful. The lack of support available also reinforced participants' views about male CSA not being enough of a problem to warrant the provision of services for men.

Campaigns are slowly being introduced to raise awareness of male rape and CSA. Survivors UK implemented the 'Real Men Get Raped' campaign across London in 2012, advertising their services with large posters in London tube stations. In America, in 2010, Oprah Winfrey hosted a two-day show ('200 Adult Men Molested Come Forward') illustrating the stories of males who had been sexually abused in childhood. Further campaigns such as these are needed to expose the impact of CSA, highlight the potential benefits of seeking help and raise awareness of available support services and networks. Scotland has a branch of the British Psychological Society (The British Psychological Society Scotland Survivors of Childhood Sexual Abuse Working Party; BPSSS), which is dedicated to raising awareness on the prevalence and consequences of CSA and support relevant work in the areas of services,

training and research on issues affecting survivors of sexual abuse. Findings from the current study demonstrate the need for similar services in other areas of the UK.

Due to the limited literature on help-seeking following CSA in male survivors, research exploring men's help-seeking in general was explored. The findings revealed that one of the principle health-related issues facing men in the UK is their reluctance to access health services, with 'traditional masculine behaviour' being implicated as an explanation for delays in seeking help amongst men (Galdas, Cheater & Marshall, 2005). The reasons and processes behind this, however, have received little attention and warrant further investigation.

The theme 'Being Male' illustrated the impact of gender on help-seeking, evident through the participants' narratives, in which the majority compared the limited or lack of resources for males to the availability of support services for females and the message interpreted 'that CSA is not a male problem'. This view is further reinforced as most practice and policy initiatives have focused on responding to women as survivors of sexual abuse. Over the past decade, the sexual abuse and violence committed against women and girls has been the driving agenda (Home Office, 2009). This is vitally important work; however recognition of male survivors as victims, and further investigation, support and research in to the needs and issues affecting both genders would provide a more balanced focus.

Existing literature has acknowledged that seeking and receiving help is a complex and difficult issue for most survivors (Gavey, 2003), and similar to findings by Alaggia (2005), Alaggia and Millington (2008) and Holmes and Slap (1998), participants in the current study found it harder to seek support because of issues related to their sex. The notion of seeking help appeared to conflict with men's views about themselves, ideas about masculinity and gender roles in society. Connell (1995) refers to the term 'hegemonic masculinity', which is considered the dominant form of masculinity expressed in social and behavioural domains such as physical and emotional strength (de Visser et al., 2009). It is important to emphasise the conceptualisation of masculinity as plural rather than singular: hegemonic masculinity exists not only in opposition to femininity but also in relation to other masculinities. De Visser et al. (2009) propose that whether a man engages in particular behaviours, and his competence in these behaviours, has implications for his masculine identity; therefore, men who resist or reject hegemonic masculinity must develop alternative masculine identities. This theme permeated participants' accounts in varying degrees, and revealed an overall similarity in terms of grappling with the concept of masculinity and what it means to be a

man, and a survivor of CSA. The individuals' narratives exposed an array of qualitatively unique experiences in relation to this phenomenon. Participants negotiated ways of being manly, for example, changing their physical appearance, possibly to compensate for their inner feelings of vulnerability. Connell (2005) note that most, if not all, men embody a range of both hegemonic and subordinated masculinities, and that men can have overall masculine identities which combine masculine and feminine behaviour.

Concerns about homosexuality emerged from the data. Participants described both fearing they were gay, and thoughts that others might presume they were gay if they sought help for CSA. Consistent with findings by Foster (2005), participants in the current study found that personal concerns with questions of sexuality troubled them, even if they have never previously experienced sexual interest in another man, illustrated by Jack and Barry, who both questioned their sexuality following being abused. Expanding on this, Etherington (1995) suggests that, essentially, men they fear they will be blamed, especially if they felt in any way aroused or had an erection; they associate the abuse with homosexuality and fear being perceived in that way. Teram, Stalker, Hovey, Schachter and Lasiuk (2006) propose that if a man is abused by a woman he will often assume that others will not take his complaints seriously. This was true for Ben, who questioned if his experiences were really abuse as they were perpetrated by a female.

Lisak (2005) proposes that the sense of 'failure as a man' makes men less likely to seek help. Furthermore, limited ideas about how men 'should' have responded to sexual abuse cause further problems, in that men both blame themselves for not stopping the abuse from happening and for struggling with the aftermath, because as men, they should have been able to cope (O'Leary, 2001). Sam described not wanting to seek help for fear of being seen as weak and compares men seeking help to men asking for directions when lost, implying that this is something that men simply do not engage in. Similarly, Jack felt that admitting that he wasn't able to protect himself was a threat to his masculinity. This view was shared amongst the majority of the participants' narratives and is consistent with findings by Crome (2006), who revealed that men are frequently hesitant to search for help because of sex-role socialisation.

Prevailing myths surrounding the phenomenon of male CSA were also considered to be a significant barrier to seeking help for several of the men in the current study. Participants' narratives illustrated their concerns about myths such as 'a boy who experiences CSA is likely

to go on to perpetrate abuse'. Regardless of the fact that there is no straight-forward causal pathway from being abused to offending, the 'cycle myth' continues to pervade. This has a profound impact on men, leading to them monitoring and viewing themselves in negative ways, stopping them from engaging in relationships, parenting or working with children (Ouellette, 2009), despite findings that demonstrate 95% of males sexually abused in childhood do not become sexual offenders (Olgoff, Cutajar, Mann & Mullen, 2012).

Relevant to both sub-themes is the recent interest in conducting therapy using e-mail, Internet chat and video conferencing, which provides opportunities for accessing support. Setting aside the continued debate on major ethical and legal issues with online counselling (Rochlen, Zack & Speyer, 2004), there may be potential benefits to reaching men resistant to face-to-face interventions. Considering the problems faced by some men and their resistance to seeking help, exploring additional options to reach these men appears to be critical (Blazina & Watkins, 1996). The findings from the current study emphasise the desperate need for funding, research and provision of services for male survivors of CSA. Furthermore, research exploring GPs' responses to disclosures and their ideas about treatment would illuminate current understanding and practice, which might aid further training in such areas.

### **Master Theme Three: The Help-Seeking Journey**

The theme 'The Help-Seeking Journey', incorporating sub-themes of 'Relationships, Hindering Aspects and Helpful Aspects', supports findings from previous literature, as outlined below. The sub-theme 'Relationships' illustrated the dynamics involved in developing and maintaining relationships, which impacted engagement with therapists and health professionals.

Participants described difficulties in trusting and engaging in relationships with others, particularly those in a position of power (therapists, doctors or employers). Similar findings are reported by Hunter (2006), who found that male survivors of CSA often have difficulty developing and maintaining relationships. Dan talked of his struggle to find work due to difficulties he experienced in interviews linked to his previous betrayal by authority figures. Drauker, Martsof and Roller et al. (2011) explain that difficulties in relationships can be described as a dialectical process, and that participants made deliberate choices about how they interacted with others, establishing boundaries that allowed, but limited, the access others had to their time, affections and bodies. These findings are supported in the current study; Joe and Ben described being hyper-vigilant and aware of their interactions with others

and acted in a particular manner to control their relationships. This manifested in the use of certain behaviours with both acquaintances and within therapeutic relationships; Joe, for example, described limiting the amount of time he spent with people before moving on and cutting off completely from them. Ben described his ability to detach from friends and acquaintances; he illustrated his attempts to keep people at a distance, including harming himself so that no one would try to hurt him. The idea of challenging the therapist was also evident in his narrative. This resonated with findings from a study by Sharpe, Selley, Low and Hall (2001). They described the outcome of providing a slow-open analytic group therapy for male survivors of CSA. The group was run by a male and a female therapist for 28 months. Meetings were weekly, and although clients were encouraged to commit to the sessions, they were not excluded if they failed to attend each week. Lack of trust was found to be a central issue. In addition, few members felt able to believe in the concern for them expressed by the therapist or other members of the group. The authors described that participants in the group expressed hostility to anyone perceived to be in authority and demonstrated a need to control the therapeutic process, either passively or actively. Examples of such behaviour included attending late or leaving mid-session (Sharpe et al., 2001). This resonated with Ben's comments about paying for therapy sessions upfront so that he could leave the session at any time, thus controlling the power dynamics. Also of interest was the finding that participants avoided expressions of emotion but channelled them through alcohol or drug abuse (Sharpe et al. 2001), a theme which appeared prevalent for a number of the participants in the current study. A greater understanding of these dynamics is illustrated by Murphy and Roe (2013), who describe issues and concerns for men on the road to healing after CSA. Their findings illustrate the behaviours of survivors of CSA, particularly the idea that men 'erect walls to keep people getting too close' (p. 76), or wearing armour or masks which become 'protective devices' (p. 76). This resonated with findings from the current study. Participants went to great lengths to prevent people getting close to them by changing aspects of their physical appearance. Ben, for example, covered his arms and body with tattoos and Sam grew a very long beard and facial hair, which he described as his protection. Such findings illustrate the importance of not judging one's initial presentation or appearance, and looking beyond the 'masks' or 'protective armour' a survivor may inhabit.

A poignant sense of the need to protect themselves was associated with being a survivor, which impacted on the development of interpersonal relationships both in and outside of the therapeutic environment. These difficulties could be explained by attachment theory, which



provides a useful framework within which to examine the role of early family relationships on the consequences of child abuse, including sexual abuse. Based on Bowlby's (1973) theory of attachment, infants' early experiences with the attachment figure in their lives plays an important role in developing their expectations about their own role in relationships and the role of others in relationships. The quality of these early relationships affects how children begin to perceive themselves and others. Childhood sexual abuse has been associated with insecure attachment styles in adulthood (Alexander, 1992). Insecure attachment can be divided into three types: Fearful (involving a high need for interpersonal acceptance and affirmation and, yet, avoidant of intimacy); Preoccupied (involving similar high needs for relationships; and Avoidant/Dismissing (involving avoidance of interpersonal attachments and high needs for self-reliance). Mezey and King (1989, cited in Coxell & King, 2010) found an 'almost universal' theme of survivors was their inability to form close relationships. Similar findings were identified in the current study. Ben described how his parents were completely detached and unresponsive to his needs physically or emotionally, as a child and as an adult. As such, he struggled with his emotions, in interpersonal relationships, with his own self-image and with trusting others. Attachment literature suggests that some insecure children do not learn to regulate their emotions due to the absence of a secure base (Holmes, 2001). This was evident for participants in the current study who either reported avoiding or denying emotion entirely, or struggling to understand their emotions. The lack of responsiveness from Ben's parents led him to conclude that there was no point in showing emotion, or asking for help. He learnt to detach himself from his experiences and from others to cope and, as such, may have developed an insecure or avoidant attachment pattern. Sexual abuse may interfere with an individual's understanding of emotions in themselves and others (Briere, 1992)). As a result, they may misinterpret the actions of others, which may explain their interpersonal difficulties. Research by O'Hagan (2006) argues that infants who experience emotional abuse from their primary caregiver only experience a limited number of emotions. Similar findings have been reported in the current study, with participants describing experiences of being unable to understand their emotions or suppressing them to the point that they become unaware of how to cope with them as adults.

An illuminating case study by Lemelin (2006) described his experience of CSA. He discusses a number of aspects similarly found amongst the current study's participants' narratives, including running away from relationships. As explained in the paper, Blaire (2002, cited by Lemelin, 2006) suggests this is a common defence mechanism in survivors of sexual abuse.

Lemelin described his justification 'I'm not running I'm just off to fight a new cause, but I wasn't' (Lemelin, 2006, p. 344). This is similar to that of Joe's and Ben's experiences of detaching from others: 'I'm off' and 'you're gone'. One wonders how this impacts the development of a therapeutic relationship, as well as impacts on personal relationships and friendships. Dale (1999) adds to this by highlighting that challenges may occur in establishing an effective therapeutic relationship with clients who have particular tendencies towards lack of trust. According to Allender (1995), 'The damage of betrayal is the deepening conviction that relationships can neither be enjoyed nor expected to last' (p. 137). Trust is essential when counselling survivors of CSA (Briere & Scott, 2006). Many CSA survivors learned at an early age to be wary of their surroundings and those in it (Leahy, Pretty & Tenenbaum, 2004) and may be cautious of counsellors for a variety of reasons (Scaer, 2001). The literature illustrates that professionals' attitudes and biases regarding childhood sexual abuse may have a deterring effect on survivors' willingness to disclose or explore issues of CSA in the therapeutic environment (Day et al., 2003; Yarrow & Churchill, 2009).

Hindering aspects of help-seeking described by participants included having to live in silence, power dynamics in therapeutic relationships, and doubts about a therapist's knowledge and competence. Dan shared his doubts about his therapist's competence, and Dave described how his therapist told him to go to confession following his disclosure of CSA, which left feeling him even more to blame. Existing literature on psychologists' perceptions of male survivors found that psychologists who held more traditional attitudes towards men tended to blame male survivors more for the abuse (Richey-Suttles & Remer, 1997). Furthermore, research by Schachter et al. (2009) with survivors of CSA highlighted a number of factors impacting healthcare interactions. These included distrust of authority figures as experienced by Ben and Dan, anxiety about being abused by the healthcare practitioner, discomfort with practitioners who are the same gender as the person who abused them, experiencing of triggers and dissociation during healthcare procedures, and feeling unworthy of care. Ben and Dave described being hyper-alert to danger and extremely suspicious of others' behaviour. Barry reported feeling uncomfortable with a female therapist; however, for Dave, Joe and Jack, the gender of the therapist was not considered a problem.

Being unable to communicate with a therapist was also considered a hindering factor, which has been described in existing literature. Dale (1999), for example, highlights that clients are often unable to express feelings of dissatisfaction in counselling. This was described by a number of participants in the current study. Theories such as Finklehor and Browne's (1985)

Traumagenic Dynamics Model and Freyd's (1996) Betrayal Trauma Theory contend that some survivors experience a disruption (as a consequence of the original abuse) to their ability to monitor, detect and respond to threatening or dangerous interpersonal incidents as they unexpectedly emerge, which renders them more vulnerable to repeat victimisation (Wager, 2012). Dave described several incidents in therapy whereby he was unable to respond as he would have liked, therefore leaving him feeling vulnerable and re-traumatised. In addition, like the males in Sharpe et al.'s (2001) study who expressed hostility towards anyone perceived to be in authority, Dan, Dave, Ben and Joe reported struggling with the 'therapist as expert' and felt that this impacted the development of an effective therapeutic relationship. Several participants described the impact of masculinity in the context of relationships. Alaggia (2010) found that men reported being affected by prevailing attitudes about masculinity and images of men as supposedly immune to victimisation. Interestingly, as a reaction against this, participants described adopting hyper-masculine stances, similarly found in the current study in Joe's account when describing his masculine presence in the therapy room.

Paying for therapy sessions was also associated with being a hindering aspect, particularly for the participants who described needing or wanting long-term therapy or extended sessions of counselling to work through problems related to CSA. Current provisions for such therapy on the NHS are limited, thus clients often enter therapy for associated difficulties (i.e. anxiety or depression) and are usually offered brief therapy with cognitive-behavioural therapy, or six sessions of counselling where provisions are available. The participants in the current study, Dave, Dan and Joe, had been offered up to six sessions of counselling, which they felt was far from adequate. Durham (2003) supports this, proposing that the expectation of recovery after a short time-limited intervention, if not successful may in itself convey a sense of failure, further impacting the survivor. Engaging for a time-limited amount of sessions led to frequent re-referrals to services, which could be considered as counter-productive, particularly considering the additional dynamics of the time taken to develop a trusting relationship for the participants, as described in theme 3.

Further insight into hindering aspects can be gained from research by Chouliara et al. (2011), which utilised IPA to explore male survivors' perspectives of support services in Scotland. Hindering aspects included continuity and consistency of services, accessibility during acute periods, managing disclosures and availability and accessibility of services. The findings from the analysis of the current study support this, in that the males described similar helpful and

hindering aspects, in particular, the challenges of finding appropriate support when needed and accessibility of services for males.

Existing research exploring helpful aspects of help-seeking amongst male survivors is limited; thus, findings from the current study add to the literature. Helpful aspects discussed by participants included flexibility in the therapists' approach, overcoming difficulties with trust, connecting with suppressed emotions, engaging with social support and feeling understood. A systematic review by Chouliara et al. (2012) exploring male and female survivors' perspectives of support services highlighted the importance of the therapeutic relationship; this has also been described by Morrow et al. (2012). Such findings are supported by the current study, with participants emphasising the need to develop a therapeutic relationship within which they trusted the therapist and felt safe enough to begin to work on their problems. A number of participants found expressive writing helpful in overcoming their traumatic experiences.

This is a novel area of research that has been explored in areas such as adapting to stressful events (e.g. Lepore, 1997) and with female survivors of CSA (e.g. Kearns, Edwards, Calhoun & Gidycz, 2010) however such research with male survivors could not be found in the existing literature. In the current study, Sam shared that writing about his experiences had been a turning point in his own recovery, giving him the opportunity to share his story. This supports findings by Antal and Range (2009), who suggest that some survivors of sexual abuse may prefer a more private and personal method to work through their emotions associated with the trauma. It has also been noted that men derive more benefit from writing than women (Smyth, 1998), perhaps because men are less likely than women to talk about their emotions in relation to CSA; however, a larger meta-analysis found no significant difference between males and females (Frattaroli, 2006). There is some evidence to suggest that renaming counselling as 'workshops' or 'problem-solving' might make it more appealing to men, particularly those who adhere to traditional gender norms (Robertson & Fitzgerald, 1992). However, such moves reinforce stereotypes, rather than challenge them (de Visser & McDonnell, 2013); therefore, further research is required to explore these dynamics.

Studies on the factors of resilience have provided useful information on helpful and hindering aspects of CSA recovery (Kia-Keating et al., 2005; Grossman et al., 2006; Daigneault, Hébert & Tourigny, 2007). Processes that appear to be associated with resilience include: meaning-making; positive re-framing; disclosure; refocusing and moving on; refusing to dwell on abuse

experience; and achieving closure. Such findings are not dissimilar to the findings of the present study. Participants' narratives illustrated themes of meaning-making and moving on to achieve closure. A recent literature review supports these findings. Marriot, Hamilton-Giachritis and Harrop (2013) reviewed fifty English language studies (1991-2010) investigating outcomes for people with a history of CSA. Numerous papers presented similar findings associated with resilience in survivors of CSA, including the identification of family support and stability, peer friendships, social support, academic success and spirituality. The authors conclude that health promotion initiatives and social policies and programmes can improve outcomes for people with a history of CSA, using both individual and systemic interventions.

A number of participants in this study described that flexibility in therapy was also considered helpful and improved engagement. In particular, Jack described the benefits of using creative approaches to express his emotions, and Ben commented on the flexibility of his therapist in his use of different approaches, for example, gestalt, inner child work and cognitive therapy. Dan, in his account, described engaging in a number of forms of therapy, including person-centred therapy, group work and Eye Movement Desensitisation and Reprocessing (EMDR). EMDR is a form of psychotherapy developed by Francine Shapiro that aims to alleviate the symptoms of post-traumatic stress disorder. EMDR is used for individuals who have experienced severe trauma that remains unresolved. According to Shapiro, when a traumatic or distressing experience occurs, it may overwhelm normal cognitive and neurological coping mechanisms. The memory and associated stimuli are inadequately processed and stored in an isolated memory network. The goal of EMDR therapy is to process these distressing memories, reducing their lingering effects and allowing clients to develop more adaptive coping mechanisms. A number of the participants felt that they benefited from different forms of support at different times in their adult lives. Indeed, existing evidence has provided support for the view that different approaches may have different contributions for different stages of recovery (Edmond et al., 2004; Nelson & Phillips, 2001). Friedrich's (1995) integrated approach to treatment exploring domains of attachment, dysregulation and self suggests a variety of strategies to help overcome the effects of CSA, including difficulties with distrust of others and forming close relationships, stigmatisation and powerlessness, and the ability to regulate emotions. In addition to this, collaboration was also considered an important aspect of therapy, which helped clients to feel part of the process. In support of this, Crome (2006) proposes that decisions of practice approaches should be client-led.

Overall, there is a distinctive lack of published research exploring the experiences of survivors and professionals working with survivors, particularly in the United Kingdom. Findings of limited research in this area can be summarised as follows: positive experiences from talking therapy focused mainly on the development of an equal, open, respectful and non-judgmental therapeutic relationship (McGregor, Thomas & Read, 2006; Phillips & Daniluk, 2004) and the provision of social support (Durham, 2003). Those who perceived others as being helpful following sexual abuse experienced more positive life changes and less psychological distress (Frazier et al., 2004; Steel et al., 2004). Negative experiences of talking therapy described by survivors included professionals being passive or unresponsive and prescription of medication with little consultation on this decision (Koehn, 2007; Nelson, 2009). Survivors also emphasised the importance of knowledge and awareness of health professionals about CSA-specific issues as well as trauma-related issues in talking therapy (Schachter et al., 2004). Comparable findings were reported in the current study.

#### **Master Theme Four: Continuing the Journey - Making Sense and Moving Forwards**

The theme 'Continuing the Journey - Making Sense and Moving Forwards' illustrated the variety of ways in which the participants gained understanding about their past experiences, and embarked on their own unique healing journey. Interestingly, participants gained further understanding by looking back on their childhood experiences with adult eyes, and it could be considered that this process of re-telling in the interviews for this research provided the opportunity for further meaning-making and reflection. The sub-themes 'Making Sense and Moving Forwards', 'Wounded Healers' and 'Recovery as an Ongoing Process' overlap and complement each other and are further discussed below.

##### **Making Sense and Moving Forwards**

A poignant theme transparent amongst participants was the need to understand and make sense of their past CSA experiences. All of the participants recognised areas of their lives that had been affected by the abuse, for example, interpersonal relationships, employment, physical health problems, and although they knew it was linked in some way, did not make the connection until adulthood. Having the opportunity to explore these areas in therapy was considered helpful for many of the participants. Others found ways meaningful to them to explore their thoughts and feelings about their pasts, for example, writing about their experiences. The complexity involved in processing the emotions and feelings relating to the abuse were evident. A sense of this is captured in the men's accounts as they reflect on the significance of CSA in relation to their adult lives and interpersonal relationships, attempting

to make sense of who they are, and how this might be consolidated with the person they aspire to become, capturing the ambiguity of participants' experiences.

The difficulties that many of the men experienced in terms of attempting to make sense of their abuse experiences are consistent with findings by Chouliara et al. (2013), who used IPA to explore experiences of recovery from CSA in male and female survivors' use of mental health services. The main themes identified included the affected self, factors hindering recovery, the hurdles of recovery and the recovering self. The recovering self was characterised by increasing confidence, assertiveness, ability to self-care and self-acceptance, and by embracing vulnerability. Similar themes were evident in the narratives of the current study, with participants describing the changes they had identified in themselves and the notion of self-acceptance. Participants described being driven to understand their experiences of abuse, and in doing so, integrate it into their lives in various ways. This is consistent with Grossman et al.'s (2006) suggestion that a fundamental aspect for survivors in their journey towards recovery is finding a way to 'make sense' of what happened to them in the past and to make meaning of the place that the abuse has in their current lives. Doing so, however, was challenging, particularly for those such as Dave who experienced sexual abuse perpetrated by a close family member. Similar findings were reported by Draucker and Martsof, (2008) and Roller et al. (2009), who highlight the challenges of making sense when sexual abuse occurs in childhood, is perpetrated by an intimate other and involved sexual activities for which they were not prepared. Both Dave and Sam described experience as helping them to make sense of their pasts. Dave spoke initially of not having the words to describe his experience as a child, whereas Sam decided it would never be an option for him to speak out. For both, being able to make sense of this as adults was considered healing in itself and enabled the realisation that they were not to blame.

Recent research by Easton (2013) introduced and assessed the viability and utility of the 'Account-Making' model for understanding the recovery process for trauma survivors. A core assumption of this model is that people who have experienced potentially traumatic events can benefit by developing accounts to describe, interpret and create meaning from the event. Easton found that amongst a large, non-clinical sample of men with histories of CSA, account-making appears to be related to better mental health. These findings are consistent with previous studies on survivors of sexual assault that found that account-making is related to positive adjustment and coping (Harvey, Orbuch, Chwalisk & Garwood, 1991; Orbuch, Harvey, Davis & Merbach, 1994). Furthermore, account-making may be related to a reduction in

psychological symptoms (e.g. depression, anxiety and suicidal tendencies). If such findings are replicated with other populations, account-making may have important implications for clinical treatment of survivors of trauma (Easton, 2013).

### **Wounded Healers**

The notion of the wounded healer places emphasis on the pain or 'wounds' of the healer, which are considered to facilitate the power to help others. This is particularly relevant for survivors of sexual abuse, who can find it both healing and rewarding to help others work through their difficulties. Grossman, Sorsoli and Kia-Keating (2006) found that male participants described themselves as committed to helping others, particularly those perceived as vulnerable, in order to make meaning of their own experiences and difficulties. Interestingly, this feature also emerged from a number of the men's narratives in the current study. Participants shared that they had participated in the research with the aim of helping others understand more about male CSA, hoping to contribute to alleviating the suffering of others who had experienced similar childhood experiences. Participants also described venturing into jobs or volunteer work which entailed helping other vulnerable people, including survivors of sexual abuse. These findings share similarities to existing research. Grossman et al. (2006) employed a qualitative design to explore how 16 resilient male survivors of CSA made meaning from their abuse experiences. Amongst other factors, making meaning through altruism was a key theme. Herman suggested this is a crucial aspect of healing for many survivors and terms this the 'survivor mission' (Herman, 1992). In support of this, findings from a number of studies suggest that men's wellbeing is enhanced not just through receiving support but through having the opportunity to support and help others (Grossman et al., 2006; Kia-Keating et al., 2010; O'Leary, 2009).

### **Recovery as an Ongoing Process**

Participants in the current study challenged the notion of a 'full recovery' and instead viewed recovery as an ongoing process involving change (see theme four: Making Sense and Moving Forwards; subtheme three: Recovery as an On-going Process). Similar understandings of recovery have been reported in existing research by Banyard and Williams (2007), who explored meanings of recovery in survivors using a narrative approach. Recovery encompassed acceptance of what happened, making peace with oneself, talking about experiences and feelings and making links to past difficulties (e.g. substance misuse/relationship difficulties). Participants in the current study reflected back on their experiences and identified positive changes they had made, providing a greater



understanding of the aspects considered important in their recovery journeys. They shared reflections of progress, and the process of identifying and working on their defences and other areas in their lives which they felt required therapeutic intervention. Overall, participants demonstrated that they came to realise that there is no quick cure for the impact CSA has; instead, they shared the view that the process of recovery is an ongoing one.

### **Implications for the Practice of Counselling Psychology**

This investigation has endeavoured to capture the rich and intricate layers of lived experiences of male survivors of CSA and their experiences of help-seeking. It is evident that although the men have experienced challenges in their early lives, all of them continue to transcend their personal challenges, drawing on a mixture of therapeutic support and the development of various inner resources. There are several implications that one may draw from this study which may be valuable for clinical practice, and these are outlined below.

#### **Understanding the Process of Disclosure**

The present study has documented that both individual and environmental factors account for delayed and non-disclosure. Consistent with existing literature, participants disclosed CSA in varied and complex ways, with several describing their experiences of disclosing after presenting in therapy with other complaints. Ray's (2001) mixed model study used semi-structured interviews to explore how the after-effects of sexual abuse from male survivors' perspectives might be useful in helping clinicians identify males with possible histories of CSA. Participants reported difficulties in forming relationships; powerlessness; isolation; and being alienated from others. The current study adds further support for these findings; once in a therapeutic environment it became possible for some of the participants to disclose that they had been abused and begin a journey towards seeking help for the associated difficulties. This highlights the need for psychologists to consider the possibility that unresolved distress may be masked by manifestations of other difficulties. For those providing therapy, these findings suggest that men might not necessarily disclose sexual abuse, despite wanting to. If clinicians do decide to ask questions about abuse histories, this needs to be in a sensitive and non-shaming way, without inferring any blame or judgement.

Sensitive responses to disclosure and appropriate approaches designed specifically for abuse-related issues are vital to successful engagement and treatment. The current study illustrated the detrimental impact of negative reactions following abuse disclosures. There is a need to

appreciate how disclosure creates the possibility for survivors to understand their abuse in an increasingly multifaceted and, ultimately, more satisfying way; thus, the findings from the current study highlight the need for more research, education and training on handling disclosures. In considering the detrimental impact of myths associated with male CSA as described by the participants, an implication for practice would be to educate professionals, parents and the general population regarding these myths in order to reframe such myths and misconceptions. Such efforts may improve responses to disclosures.

In acknowledging men's reluctance to disclose CSA, it becomes more difficult to explore this topic (Diamanduros, Cosentino, Tysinger & Tysinger, 2012). Future research could explore this phenomenon using methods that do not require participants to meet a researcher face-to-face, such as interviewing by Skype or other online support networks. Craig (2010) has found the Internet to be a useful method of providing support for male survivors who wish to seek help and advice whilst remaining invisible.

### **Men and Masculinity**

The impact of growing up in a society which proposes that males should behave and act in a certain way has implications for help-seeking. Where possible, such views must be challenged, and men educated to know that they are not at fault or to blame for having been sexually abused in childhood. It was evident for the participants in the current study that seeking help was considered a threat to their masculinity. Ouellete (2009) suggests that the phenomenon of male abuse is incompatible with current dominant discourses associated with masculinity, and believes that this stereotype is so ingrained in our culture that it not only affects society, but also professionals and male survivors themselves.

As de Visser and McDonnell (2013) note, failure to question socially constructed definitions of gender may reinforce stereotypes that restrict men's and women's opportunities. They recommended that men's concerns about masculinity need to be reframed to encourage healthy 'masculine' behaviour. To understand and change men's unhealthy behaviour, it is important to consider three related issues: the relationship between different discourses of masculinity; the role of health-related behaviour in the active construction of a masculine identity; and the meaning of 'masculine' behaviour and masculine identity in young men (de Visser & Smith, 2006). Thus, as health professionals we can find ways to encourage men to develop healthy masculine identities (de Visser & Smith et al., 2009).

Addis and Mahalik (2003) proposed that reducing the influence of restrictive masculinity norms would increase men's willingness to seek and receive help. Suggestions including normalising men's difficulties, and encouraging opportunities that enable reciprocity, such as engagement in men's groups, were noted.

### **Coping**

Being aware of the way a male survivor might present in terms of their protective coping strategies is also of importance. As Murphey and Roe (2013) state, 'It is often easier for men to hide behind disguises than face reality' (p. 77); therefore, respecting these coping mechanisms is important as they have enabled survival. Encouraging a survivor to reflect on these coping mechanisms in therapy and consider whether they remain helpful in adulthood can facilitate change, as found by participants in the current study, who slowly let down their barriers and learnt to trust.

### **Helpful Aspects of Seeking Help**

Learning from participants about the things they found helpful when seeking help provided valuable information that can be used by health professionals to enhance understanding and practice. Although evidence of male survivors' experiences of different types of therapy and of different theoretical approaches is limited, participants in the current study shared how flexibility in therapy, and the use of a variety of approaches, helped them. There is some evidence to suggest that different approaches may have different contributions for different stages of recovery (Edmond et al., 2004; Nelson & Phillips, 2001). Thus, approaches such as Friedrich's (1995) integrated approach to treatment exploring domains of attachment, dysregulation and self might be useful to consider when working with male survivors. This approach suggests a variety of strategies to help overcome the effects of CSA, including difficulties with distrust of others and forming close relationships, stigmatisation and powerlessness, and the ability to regulate emotions. The traumatic nature of CSA affects a child's ability to regulate his emotions, thoughts and behaviours, leading to some of the specific symptoms outlined in the Post-Traumatic Stress Disorder model. All of the participants reported these impacts at some point in their lives; therefore, further research reviewing the efficacy of this approach in adult males would be useful and may provide effective intervention strategies above and beyond current practice.

Both engaging in therapy and the use of self-help have also been considered as effective in the participants' journeys. Three of the participants stated that the use of literature enabled exploration of others' experiences, helped them realise they were not alone and facilitated new understanding. Texts such as *Victims No Longer* (Lew, 2004) and *Overcoming Childhood Trauma* (Kennerley, 2009) provide accessible information and worksheets which can be used by individuals or in therapy. These are designed to assist with understanding and offer methods to challenge assumptions and overcome problems. Easton's (2013) research on account-making could also provide a useful framework for men to understand their difficulties. In light of the current findings, it seems that research investigating methods for men to facilitate the process of making meaning through account-making would be a valuable addition to the current literature. Future research could investigate the usefulness of such methods of intervention with male survivors, particularly those who find it more difficult to engage in person or initially prefer to work through their difficulties by themselves.

Findings from the current study emphasise the need to consider different forms of support, enabling different routes for men to access help. Drawing from some of the features that emerged from the data that appeared to bolster feelings of strength and resilience for the men in this study (social support, trust, feeling understood) may be valuable for guiding therapeutic intervention.

### **Therapeutic Relationships**

As found in the results of this study, participants' preconceptions about a therapist could impact the development of a therapeutic relationship in the initial stages. Participants made initial judgements about therapists based on a variety of factors, and without meaning to, therapists may display characters or behaviours that are perceived negatively by prospective clients for a variety of reasons. In the current study, survivors described being hyper-vigilant and wary of the therapist's presence in the room, offended by certificates of expertise and competence and disappointed in the therapist's response to a first disclosure. Being able to raise questions and discussion about a client's expectations and individual needs during an initial session may help to alleviate anxiety and create the conditions for a client to express themselves.

Findings from this study have emphasised the importance of considering factors such as historical difficulties in clients attachment relationships and the impact on the development of the therapeutic alliance, in particular, how coping strategies such as avoidant-coping might impact a survivor engaging with a therapist. It is important to ensure that practitioners are informed and able to work with these dynamics, and demonstrate a willingness to hear about a client's problems without disbelief or judgment.

Also of importance was the concept of trust and how this manifests in the therapy room. Participants illustrated their ambivalence by testing a therapist before trusting them. As such, it is important to consider how one presents when working with survivors of CSA who may struggle with authority figures or the view of the 'expert' and 'patient'. Being aware of dynamics such as these will hopefully improve engagement with survivors who present in therapy. Developing a trusting relationship with a therapist was considered a positive aspect of help-seeking in the current study. Hunter (2009) asserts that the sexually abused boys who do search out professional help will often be misdiagnosed or simply not taken seriously, which negatively impacted the development of therapeutic relationships. This is consistent with findings from the current study. Lab et al. (2000) found that whilst professionals are aware CSA exists, they fail to realise the need to enquire about this when assessing patients. A logical response would be for all professionals to incorporate a routine inquiry about a history of CSA into their assessments (Havig, 2008). Future research could investigate current disclosure experiences and professional responses to reveal current practice amongst health professionals. In addition, relevant training should be offered routinely to those health professionals who may need to enquire about childhood trauma. The findings of this study provide support for such training.

Therapists undoubtedly should be mindful of some of the common reported issues experienced by male survivors. Given the relationship difficulties the men's accounts seem to suggest, especially in relation to developing trust within a therapeutic setting, it seems that providing an environment with contained boundaries may be particularly crucial to ensure both physical and emotional safety. Gilbert and Leahy (2007) propose that the therapeutic relationship may facilitate affect regulation through the provision of safety, security and connection, as it 'breaks the client's sense of isolation, confirms self-experience, and promotes self-empathy and self-exploration' (p. 47). Furthermore, Rogers (1951) asserts that the 'the probability of therapeutic movement in a particular case depends primarily not upon a counsellor's personality, nor upon his techniques, not even upon his attitudes, but upon the

way all these are experienced by the client in the relationship' (p. 65). Thus, the significance of the therapeutic relationship to the healing process cannot be underestimated.

### **Increasing Service Provision**

According to Draucker and Petrovic, (1997), there is little clarity about whether CSA survivors perceive their needs and service provision in the same way as clinicians. In support of this, the current study's findings illustrated that professionals demonstrated little knowledge of how to support male survivors of CSA and a lack of awareness of support options. Participants demonstrated that there is often a short-window period where men attempt to seek help, perhaps during a time of crisis; therefore, it becomes imperative to consider access to services and resources and to reduce waiting times for consultations or assessments. A review of local service provision, similar to that carried out by Nelson (2009; 2011) in Scotland, would also enhance current knowledge of the resources and availability of services, which would then inform a needs assessment of what needs to be done to respond to, and improve services for, male survivors. Designing, developing and marketing services specifically for men would be of benefit. Existing research has explored alternative routes to providing support for men. Craig (2010), for example, explored the use of the Internet as a support medium. Other research exploring barriers to men's health behaviours has discussed factors such as renaming counselling as 'workshops' (Robertson & Fitzgerald, 1992), with the aim of appealing to men who would not consider going to counselling. In addition, research carried out in Australia has established that there is a growing evidence base to support the benefits of enhancing group options available to men who have experienced childhood sexual abuse (O'Leary & Gould, 2010).

Curtois (2004) suggests, in light of the wide variety of clinical disorders associated with a history of CSA, and the complexity and tenacity of many of the problematic feelings and behaviours of these clients, an understanding of the mechanisms by which CSA leads to mental health problems, as well as the mechanisms by which recovery from CSA takes place, would enhance counselling practice and education. Participants in the current study described traumatic experiences and ongoing psychological and physical problems associated with CSA; however, they found little effectiveness in the treatment they were offered. For the majority, this was six sessions of cognitive behavioural therapy, which was considered, if anything, to be potentially counterproductive. Future research identifying the services that voluntary organisations provide would also be of benefit; nevertheless, it is recognised that

these services are also subject to funding provisions and vary in different geographical locations.

From the findings in this study, it is evident that the participants have spent many years either searching for, or in various forms of therapy, either self-funded or via repeated referrals through the NHS. Considering the frequently cited figures and prevalence of CSA amongst males and the associated impact of psychological problems, future research should endeavour to explore alternative support to male survivors. As the findings from this study illustrate, there does not appear to be a straightforward approach to addressing the difficulties associated with CSA. Nursing, healthcare and psychology courses should encompass training on childhood sexual abuse to enable healthcare practitioners to respond to the complex needs of survivors of sexual abuse. Training courses on specific difficulties, such as emotional regulation, relationship difficulties and overcoming barriers to trust with particular relevance to CSA, would be beneficial. Several London-based voluntary organisations run courses such as these; however, due to their specific nature, such courses may not be widely attended.

Existing mental health promotion campaigns often focus on the importance of recognising the signs of emotional distress and on the value of seeking support. Such campaigns may assume a level of self-awareness and a willingness to seek help that many men may not possess. There is some evidence that messages that draw on 'traditional' male attitudes (e.g. 'facing up to things'; 'having the courage' to act, etc.) may be effective. It may also be necessary to work to change some men's perception that to care about one's mental health is 'un-masculine' (and the associated belief that mental health services are designed to the needs of women). It is probable that some men who are in need of professional help remain unknown to mental health agencies and other service providers. It is important to find ways of reaching out to these men to ensure that they at least have the opportunity to consider using services. Men in distress often exhibit difficulties in other areas of their life, Alcohol and drug misuse – which may have been used as a coping mechanism – are common, as has been illustrated in this study.

Joined-up approaches, which include the involvement of social care, employment, and housing providers, may be of particular value for men, who sometimes lack supportive networks of their own. Professional training is an important element in making progress; in particular, offering training in relation to the most important issues in male mental health

may be particularly useful, given the range of the issues that have been identified for the men in this study. CSA has been associated with a number of mental health problems in adulthood, thus highlighting the need for psychologists to consider the possibility that unresolved distress may be masked by manifestations of other difficulties i.e. substance use. It is imperative that practitioners take into account the unique experiences of men and are able to use a range of techniques to explore their difficulties. Thus, Counselling Psychologists, with their diverse backgrounds in training, can offer flexibility in approach and respond to the individual needs of men, utilising interventions from a variety of frameworks at different stages in the healing journey. This requires future exploration using a larger sample of male survivors.

### **Suggestions for Further Research**

A consistent theme in enhancing men's wellbeing is the importance of easing men's sense of isolation in relation to their experiences of sexual abuse. Whilst women's services have grown and healing modalities specific to female CSA have been of focus, the male population remains severely underserved. Services are challenged to reach out to men in a culture where men are reluctant to access services. This may be a result of rigid adherence to male gender roles, which severely constrain and inhibit disclosure. Moreover, the socialisation of male's sets up negative attitudes towards help-seeking behaviour and can further impede substantive healing. Challenging the stigma of being a CSA survivor and increasing public awareness on this phenomenon would establish a community that accept and respond to CSA more optimally. This process, however, is likely to be a slow endeavour. Health professionals working with survivors need to be aware of particular challenges men face in their help-seeking journeys, for example, in developing therapeutic relationships, which are considered a key aspect in facilitating engagement. In addition, it is important to recognise social contexts and how these might impact males seeking help. Therefore, whilst always treating clients as individuals, it is important to listen to their concerns and contextualise them within the context of cultural and societal backgrounds, considering aspects such as such stigma and social attitudes and how these shape both responses to and the ability to support survivors of CSA. Given that we know that men are less likely to access support if they need it, the first steps to engage with a service are often tentative. Confidential and anonymous sources of information, such as telephone help lines and websites, are well used by men and could be used as 'stepping stones' to accessing services (Wilkins & Baker, 2004),



offering sites of service delivery that are especially relevant for male survivors of CSA (Craig, 2010; Foster, 2011).

This study has sought to enhance understanding and raise interest and further questions about the help-seeking process for adult male survivors of CSA. The topic of the study itself is open to be further explored in many areas, in particular, the following areas warrant further investigation: professionals' views and experiences of, and challenges with, dealing with disclosures; survivors' views and experiences about treatment modalities to CSA therapy; the contribution of a trusting professional relationship to the recovery process; and experiences and needs of survivors of different sexual orientation, as well as survivors from a variety of ethnic groups. Whilst it is clear sexual abuse does cause great harm and distress, it would also be of benefit to understand how it is that despite these harms, many men manage to live satisfying and fulfilling lives, often without recourse to professional assistance (Anderson, 2008; Gonsiorek et al., 1994; Miltenburg & Singer, 2000).

Overall, the findings from the current study add to and expand findings from the previous literature in illustrating the extreme difficulties that can arise in breaking the silence and speaking out about sexual abuse. As health professionals we need to question assumptions that make it difficult for men to speak out about CSA. Research suggests that those who are able to discuss sexual abuse (rather than just tell someone about it) within one year experienced fewer mental health symptoms (O'Leary et al., 2010); thus, opportunities for engaging in support earlier should be made available. Future study requires more in-depth research into the experiences of male survivors on disclosure and effective therapeutic intervention. Until then, healthcare professionals should be aware of and sensitive to the possibility of sexual abuse histories in their male clients.

## **Evaluation and Critique of the Research Study**

Chapter 2 (Methodology) described the epistemological stance, methodology and procedures employed to explore the topic of 'Help-Seeking in Adult Male Survivors of CSA'. The following section of the discussion evaluates and critiques the study in terms of validity, and its strengths and weaknesses, before offering considerations for future research.

Whilst the criteria of objectivity and reliability are traditionally considered in evaluating research (Madill et al., 2000), such do not apply in the current study as the results of the analysis are based on the unique findings of the individuals who took part in the study. The aim was not to produce a generalisable theory; therefore, the results cannot be said to be true or false, but will vary according to the context in which the data were collected and analysed. As such, the analysis presents one possible angle and will be inevitably shaped by the researcher's interaction with the participants and the data.

Yardley (2000; 2008; 2011) offers a useful framework within which to evaluate and demonstrate the validity of IPA research, describing four key principles (sensitivity to context, commitment and rigour, transparency and coherence and impact and importance). These criteria are advocated for use in studies employing IPA (Smith et al., 2009); however, it is recommended that these guidelines are not used rigidly, but are open to flexible interpretation (Yardley, 2008). These guidelines were used to assess the validity and quality of the current study.

The first criterion is that research should show sensitivity to context. This has been demonstrated by the provision of an extensive introduction to the research which introduces and reviews the relevant theoretical and empirical literature relevant to the topic. Throughout the research, sensitivity to participants' perspectives and their accounts has been taken in to account and reflected on in supervision, particularly during the completion of data analysis. The researcher has also considered societal and cultural aspects and the impact on the attitudes, beliefs and experiences of the participants and how these might have impacted or be reflected in the results.

Commitment, rigour, transparency and coherence involve the clarity and power of descriptions, transparency of methods and data presentation and the communication of the fit between theory, method and reflexivity. Commitment concerns one's in-depth engagement with the topic, developing competencies and skills in relevant methodology,

thorough data collection and presenting sufficient interview information to justify decisions and support the findings (Yardley, 2000). Commitment to the research was demonstrated throughout the research process, from the initial stages in designing the research to the writing of the findings. Commitment to the topic of research can be illustrated by the researcher's attendance at conferences and workshops on CSA and undertaking of voluntary work at a service that supports survivors of abuse in childhood.

Rigour relates to the overall planning and implementation of the research design and is concerned with whether the study has been carried out in a logical, systematic way. Qualitative researchers are encouraged to provide a detailed example of how the research is conducted (transparency). The aim is to give the readers enough information for them to judge the applicability of the findings to other settings. Auditability involves providing a sufficiently clear and full account of the research process so that the reader can judge the dependability of the qualitative study (Lincoln & Guba, 1985). Rigour was demonstrated by ensuring that data collected was relevant to the research aims and topic in question, and then analysed in depth, whilst maintaining the clients' experiences at the forefront. Themes were checked to ensure they were reflective of the content of the transcripts and experiences shared by the participants. Extracts were also shared with the researcher's supervisor to ensure that interpretations had meaning and were relevant to the quotes extracted. Auditability was illustrated by providing an audit trail, documenting the data, methods and decisions made about the research process, from designing the research question to conducting the analysis. Excerpts of transcripts were shared in supervision to check themes and relevant quotes were reflective of the material.

Transparency involved the explicit detailing of the data collection process and providing a clear description of how the analysis was undertaken. This was demonstrated by providing verbatim extracts and examples of the analysis process. Dahlberg, Dahlberg and Nystrom (2008) highlight that the best phenomenology illustrates the complexity, ambiguity and ambivalence of participants' experiences, and advise that researchers need to 'be careful not to make definite what is indefinite' (Dahlberg et al., 2008, p. 94). The researcher has endeavoured to illustrate this throughout the data analysis and discussion section. In addition, complete transcripts of all interviews have been submitted to City University as part of the completion of this study to further support the demonstration of transparency, and a reflexive diary was maintained throughout the duration of the research study. The methodology chapter has discussed coherence, demonstrating that the research question,

epistemological stance and methodology form a consistent whole, and are an appropriate fit between the research being carried out and the underlying philosophical assumptions of the approach being followed (Yardley, 2000).

In an evaluation of the contribution of IPA to existing literature, Smith (2011) proposes that a number of criteria need to be met to demonstrate 'good IPA'. These criteria state that the paper should have a clear focus for the research, and present strong data, illustrated by the extracts presented in the analysis section. Smith also states the paper should be rigorous, with the aim of providing transparency for a theme, which should be well presented in the analysis, providing extracts from at least half the participants in each theme (Smith, 2011). The analysis should be interpretative, not just descriptive, with the author illustrating the ways in which extracts contribute to each theme. This requires engagement in the double hermeneutic: trying to make sense of the participant, and trying to make sense of their experiences (Smith, 2011). The analysis should also illustrate both convergence and divergence amongst themes, detailing how participants manifest the same theme in particular and different ways. Finally, Smith states that the paper needs to be 'carefully written', leaving the reader feeling engaged (Smith, 2011).

The researcher considers that the focus for the research was clear and also relevant when considering the gap in the literature of research exploring experiences of help-seeking in male survivors of CSA. Data collected were detailed and in-depth, providing rich and intricate examples of men's experiences. The themes were presented to illustrate participants' experiences and were grounded in the data collected, demonstrating transparency. Finally, contrasting and similar views and experiences were shared and described to illustrate the participants' experiences.

The current and previous chapter have drawn attention to a neglected area in existing literature; as such, the research is considered to benefit both the field of Psychology and Counselling Psychology. It is the researcher's opinion that this study has shed some light on and created awareness regarding some of the issues that sexually abused males experience in their help-seeking journeys. In addition, the findings and discussion have raised further questions for exploration and avenues for future research which may further expand the scope and knowledge pertaining to the field of Counselling Psychology.

One of the strengths of this study is its utilisation of an in-depth, descriptive qualitative methodology, one-on-one interviews, to gather information from participants. One-on-one interviewing gives researchers the ability to 'give voice to survivors' (Reinharz & Chase, 2002). Participants were encouraged to share their stories in their own words without the restrictions of specific questions or close-ended response categories, thus achieving a more valid understanding of the topic than what could have been achieved through the use of a more rigid approach (Carr, 1994). Another of the strengths is the potential benefit to the participant in taking part. Each participant described his inclusion in the study as a positive experience. The additional benefit of using Skype for two of the interviews enabled participation from a survivor who had not previously spoken out about his experiences. Future research could utilise this method to reach men who have not yet sought support to further understand barriers to help-seeking.

### **Limitations**

Qualitative research focuses on the lived experiences of the participants, rather than making claims about the generalisability of results. In addition, IPA is committed to understanding how a particular experience is understood from the perspective of particular people in a particular context (Smith et al., 2009). As such, the current study was limited to the findings from the interviews of seven male survivors of CSA and cannot be generalised to all male survivors of CSA. All but one of the males had sought help for CSA; thus, this sample of participants may have been more willing to talk about their experiences than those who have been unable to speak out or seek help. In addition, those who had sought support had opportunities to reflect on and process feelings through counselling or group therapy, which may have provided them with a greater ability to articulate their experiences. It must be noted, however, that for one participant, this was his first experience of speaking out to anyone outside his immediate family about his experiences. Data gathered may be criticised as participants provided retrospective accounts of help-seeking. Recounting events such as these might be subject to memory failure, distortion and revision of events. However, this is not a concern as the focus in IPA and as a Counselling Psychologist is not to question the validity of participants' or clients' accounts but to understand how people make sense of themselves and their experiences.

It also became apparent during the process of analysis that participants' experiences might have varied depending on characteristics of the abuse, such as the age at which the abuse occurred, the relationship with the perpetrator and the length of time of the abuse. These

factors may have contributed to differences amongst the help-seeking experiences. This could be further investigated in future research.

Purposive sampling, the method used to recruit participants for this research, might also be considered a limitation. Purposive sampling enables the selection of participants who meet specific criteria, in this case, adult male survivors of CSA. Those that took part were self-selecting and made contact with the researcher following the advertisement of the study. It might be the case that survivors at advanced stages of recovery or those who are faced with challenges in their recovery might have come forward, thus presenting a one-sided representation of the help-seeking process. In addition, only participants who live in the UK were considered, which further limits the inclusion of possible participants that may have met the criteria for inclusion in this study based on their country of residence. In addition, geographical diversity must be taken into consideration. Participants in different areas will have access to different services and this might have impacted the findings. Further research exploring particular geographical areas might be beneficial to understand how support is accessed within a particular area.

Due to the qualitative approach of this research, the researcher herself, due to being immersed within the process, has become a part of the study. This may be considered a limitation with regard to the subjective interpretation of the findings of this research. The researcher was not male, nor a survivor of sexual abuse; therefore, the interpretations of the data come from a place of trying to understand, rather than from personal knowledge. This may have influenced the outcome of the study, the themes that were focused on and the way in which information was conveyed. Furthermore, the majority of the participants in this study were sexually abused by male perpetrators; therefore, it is possible that if the researcher had been male, there could have been differing effects on the partaking of the participants, their openness in relaying their stories and the outcomes that have emerged. This has been discussed further in the methodological reflexivity section at the end of this chapter.

Another possible limitation might be the lack of definition provided around the term 'help-seeking'. The researcher chose to leave this to the participants' own interpretations to gain an understanding of the meaning of help-seeking for them. In addition, the way in which participants seek help might be considered differently by another survivor. This was evident

from the transcripts. Barry, for example, talked of help-seeking in terms of going to the police, whereas other participants spoke about therapy and counselling.

### **Methodological Reflexivity**

As stated in the introduction section, research on male CSA suffers from a number of problems, one being the distinct lack of research utilising samples of male participants. The current study utilised the qualitative approach of IPA to explore the help-seeking experiences of adult male's survivors of CSA.

As a methodology in its own right, rather than simply a means of analysing data, IPA involves the detailed examination of participants' 'life-worlds', their experiences of a particular phenomenon, how they have made sense of these experiences and the meanings they attach to them (Smith, 2004). This offers an understanding that can be used to expand on or contextualise existing quantitative research and to inform understanding of novel or under-researched topics. A more comprehensive overview of IPA is outlined in the methodology chapter. Although other methods were considered, it was felt that use of IPA in this study has enabled the exploration of participants' experiences, revealing rich details about their experiences of help-seeking. Interviews were conducted in a flexible manner, which allowed the exploration of novel areas that the participants introduced (Smith & Osborn, 2008). Two interviews were conducted face-to-face using Skype, thus enabling participants from different areas of the UK to take part. This worked extremely well, with both participants stating as such.

Smith et al. (2009) describe that IPA is not a prescriptive set of rules to be followed. As such, its application in each study is unique. In engaging with the data, I explored and interpreted the meaning of the participants' accounts during the analysis and writing up. One of the struggles I faced was engaging in what Smith (2004) refers to as the 'double hermeneutic', emphasising the two interpretations involved in this process: the participant's meaning-making (interpreting their own experience), and the researcher's sense-making (interpreting the participant's account), (Smith et al., 2009). I felt the conflict between remaining true to the participants' accounts to not being interpretative enough. Again, supervision enabled me to discuss my themes to ensure I had an appropriate balance, and offered an analysis of the phenomenon which illustrated both my participants' experiences and conveyed my own interpretations (Eatough & Smith, 2008). I found this a challenging process as each interview told a story and I did not want to discount any of the information as unimportant. After

extracting data for themes I encountered difficulties finding a concise name for the theme that captured the depth and richness of the participants' experiences. I found it helpful to return to the original transcripts both during and following the analysis in order to check that quotes selected fitted themes. I also found that reading it again at this later stage opened my eyes further to additional themes not relevant to help-seeking which deserve attention for future research projects.

Criticisms of IPA highlight the potential scope for the researcher to interpret the data with influence from pre-existing theoretical frameworks or personal bias (Willig, 2008). I was particularly aware of this (as discussed in the personal reflexivity section above). In an attempt to address this criticism, verbatim extracts are provided alongside interpretations to invite readers to assess and evaluate the researcher's interpretations for themselves (Bolas, Wersch & Flynn, 2007). The use of IPA has reinforced the importance of attending to individual subjective experiences, and the approach fits in well with my role as a Counselling Psychologist, whereby I try to engage, understand and respect my client's individual experiences. This study was based on the experiences of seven men who identified themselves as having been sexually abused in childhood, and their experiences of help-seeking. The sample can be considered as fairly homogenous; however, it could be considered that sampling men from different geographical locations could perhaps bias the findings. Areas outside of London, for example, may have different provision of services. Considering the focus in IPA of individual experiences and the meanings ascribed to these, any data gathered was considered as valuable and had the potential to provide opportunities for learning about men's experiences. Interestingly, the majority of participants who took part lived in London, and of the two that didn't, one reported writing about his experiences as a form of help-seeking and the other described similar difficulties to other participants in finding help. The aim in IPA is not to generalise the findings, but to examine how a particular phenomenon has been experienced by the individual, allowing for an exploration of what is shared, and also what is unique (Smith et al., 2009).

### **Personal Reflexivity**

The following section discusses my personal reflections and the influence of my role as a researcher in the current study. I have moved to a first-person narrative because the aim is to describe and account for my personal interaction with the research, the participants and the data produced.



Having decided to research the help-seeking experiences of male survivors of CSA for my Doctoral thesis, I attended a three-day conference in Nottingham where survivors and professionals presented workshops on different aspects of sexual abuse. It was encouraging to see the numbers of men in attendance, considering the frequent myths that men do not want or seek help. This encouraged me to explore this topic for the current research. I have found that my training as a Counselling Psychologist has been instrumental in helping me through the challenges of completing my thesis in a number of ways. Firstly, being open to consider the range of theories and therapeutic approaches presented has enabled me to advance my own knowledge as both a clinician and a researcher, and has broadened the lens within which I view a particular phenomenon, in this case, CSA. Secondly, the skills I have acquired during my training have been valuable in carrying out my interviews with the participants. I reverted to the core conditions of Rogers (1957), showing my participants empathy and congruence, showing unconditional positive regard and remaining genuine with them at all times. The term 'empathy' refers to the ability to set aside one's own experiences and perceptions of reality and, instead, sense and respond to the experiencing and perceptions of the other person (Mearns & Thorne (2007). Congruence refers to the concept of being genuine and aware one's own feelings, perceptions and movements, and unconditional positive regard involves the accepting the participant for who he is without evaluating or disapproving of particular feelings, actions or characteristics (Rogers, 1957). As I entered into the private worlds of the clients through their narratives, I felt as though I was experiencing with them, as they recounted their experiences. Genuineness, for me, refers to how I presented myself with my participants. It was important for me to be genuine with my participants and at all times I felt free to be myself.

I was particularly aware of my chosen terminology of 'help-seeking' and did not want to assign specific criteria for this. Instead, the participants talked about their own unique experiences of 'help-seeking'. As a Trainee Counselling Psychologist, I am perhaps familiar with hearing accounts of traumatic experiences; however, listening to each participant sharing his story was a unique experience for me. I was able to attend fully to my participants without thinking about formulation, interventions or treatment, therefore providing a different experience than in my clinical practice, and this enabling me to enhance my research skills. During the interviews, I endeavoured to bracket my existing knowledge of CSA and instead focused on the individual experiences of the participants. From my experiences of working on the telephone line at NAPAC, I was unsure what to expect when meeting my participants; meeting someone face-to-face is very different from speaking over

the phone. I found that the participants seemed to fit two different presentations: several appeared quiet, shy and were physically small in appearance; the others had a masculine-type presence, sat upright and forward and spoke with strong, deep voices. I was particularly interested in the way they spoke about their experiences, with some using humour but conveying visible contrasting emotions through their facial expressions, including shock, sadness, exasperation and anger. At times, I felt in awe of the courage and strength evident in my participants and was struck by my urge to convey this to them. Working at that time as a CBT therapist, my instinct was to challenge the participants' assumptions (such as considering themselves as to blame); however, I refrained from doing so, and was mindful that my role was to be a researcher and not a therapist. Following the analysis and during the write-up process, I reflected on the differences between the type of abuse experienced (i.e. whether the abuse was perpetrated by family members or teachers at school), and the age at which the males were abused. Initially, I had not anticipated that this might impact the outcomes; nonetheless, the topic deserves attention and would be an interesting topic for further research to consider.

On several occasions I noticed my interviews over-ran; however, I checked participants were comfortable with this and all were happy to continue. Reflecting on this afterwards and during supervision, I realised that I had wanted to allow participants the time and space to share their experiences without imposing the structure of my questions or timeframe upon them. I was also conscious of imposing on the participants' stories with my own interpretations. Etherington (2004) writes about the importance of supervision in developing reflexivity and understanding when conducting research, and I found it instrumental when discussing how to present my findings in order to do justice to both the participants and the topic. I also found it helpful in processing my thoughts and reflections in relation to both the topic of sexual abuse and the participants' narratives. In therapy I could address the emotions that arose both during and following the interviews, and reflect on my limits in terms of my knowledge of CSA, and in doing so, recognised the value of knowing one's own limit of competence. I also discussed my ability to respond sensitively when participants discussed experiences such as anal rape or the impact of having an erection. Several of the participants checked that I was comfortable hearing such information and I answered honestly, stating that I was, as long as they were. This perhaps helped participants feel more at ease in sharing their stories, and knowing that I could contain this was considered therapeutic in itself. Initially, I wondered how participants might feel talking to a female researcher; however, during the interviews, several expressed directly that they found it

easier than talking to males. Of interest is that the majority of the participants shared their experiences explicitly and freely, despite being informed that they did not have to discuss the abuse itself, whilst others appeared to want to protect me from hearing their story, and skimmed over details of the abuse itself. This is illustrated by the significant difference in the extracts selected for the themes. As is evident, some participants provided lengthy accounts with vast detail; others offered brief statements, sharing much less. This perhaps highlights something further about participants and illustrates a distinction between those who possibly felt more comfortable in talking to me, and those who perhaps didn't. Also of interest was that several participants commented openly about their negative experiences with psychologists who proclaimed to be 'experts'. From attending the Survivors conference, I was aware that a large number of survivors of CSA had negative opinions of health professionals, in particular, psychiatrists and psychologists. I recall refraining from my desires to respond with 'we aren't all like that' to avoid influencing the remainder of the interviews and potentially impacting the outcome. I was, however, aware of a need to demonstrate to my participants that as a trainee, I was not an expert on the topic of CSA but wanted to hear about and understand what they had to say. This was perhaps to encourage the development of a rapport that might have been contaminated if participants had perceived me differently. This also enabled me to remain ethical in relation to my presentation with the participants.

Although this was an exploratory study I did anticipate that I might hear about participants having difficulties finding support, which was reinforced by experiences of working at NAPAC and meeting male survivors at conferences who also shared their difficulties accessing support. I found it interesting to hear about how relationships developed between participants and their therapists, and also how power dynamics came into play in the therapy room. This reminded me of difficulties in my own work, in developing therapeutic relationships with clients who had experienced sexual abuse. I reflected on my own practice and occasions where a client had decided to end therapy or did not return after a first session and this highlighted to me that it may not be the fault of the therapist, but something important for the client that might prevent engagement at that time. Furthermore, I realised the amount of courage it takes to begin therapy, and that some clients might not be ready to engage in therapeutic work. This has important implications for the understanding of these findings. From reading the results of the analysis section, one might assume that many therapists are unable to work with survivors of sexual abuse and/or respond negatively to disclosures. The quotes selected have been chosen to illustrate some of the traumatic experiences the participants encountered; however, by no means does this imply that all

therapists will act in this manner. Although I was shocked to hear of some of the distressing and traumatic experiences in relation to disclosures in therapy, I was also pleased to find that they did go on to find help and support that met their expectations and helped them with their difficulties.

The research process itself has been demanding yet enlightening and I have learnt a lot about the topic of CSA. My initial naivety in carrying out the project in the available time-scale soon became apparent; however, despite obstacles and personal challenges along the way, I remained motivated and passionate about completing the research. At times I have been overwhelmed and saddened by the participants' experiences, not in the hearing of these, but when reflecting on how society as a whole has contributed to the problems these participants faced in being able to speak out, and seek help. I hope that this research contributes to the understanding of the complexities of help-seeking and the various dilemmas men may face in seeking help, and in doing so, enhance knowledge and practice amongst professionals who work with them.

### **Concluding thoughts**

The aim for this research was to give voice to a group who have traditionally been stigmatised and silenced. Through employing IPA as a methodology, this study has explored in depth the experiences of men from their own voices, revealing a broader understanding of how men seek help, and the complex dynamics that can accompany this process. It is hoped that this has provided rich descriptions of the life-worlds of the participants. Joe's, Ben's, Sam's, Jack's, Dave's, Dan's and Sam's narratives demonstrate courage and perseverance. Through providing a better understanding of these men's experiences, it is anticipated that this will inform Counselling Psychology and raise discussion and debate about therapeutic practice with male survivors of CSA, and in particular, provide therapists with a more in-depth understanding not only of the struggles and challenges experienced by these men, but also of their capacity for survival and overcoming adversity. To conclude, I would like to share a quote illustrating the courage of one of the participants who spoke out for the first time during his interview, and his reflections on beginning his journey of help-seeking;

***I'm proud of meself for having the balls to tell everybody now what went on.  
And I'm even proud of telling you because this is another step you know, and I  
think it's a step that will hopefully help somebody else (Sam, P7, L33 & P8, L1-2)***

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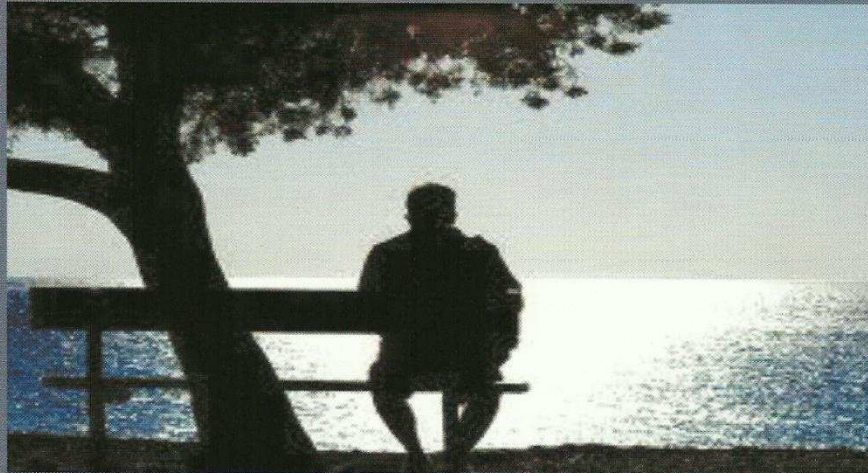
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## Appendix A – Participant Recruitment Flyer



### The Process of Help Seeking

#### *Are you an adult male survivor of childhood sexual abuse?*

Often men's voices are not heard, particularly concerning the subject of childhood sexual abuse. Learning about the process of help seeking for male survivors is a vital step towards advancing knowledge and improving understanding of this area.

By participating in this research, you can provide valuable information about your experiences, whether you have sought help or not, which will improve understanding of the aspects involved in the process of help-seeking.

If you would like to participate in this research and share your experiences, you will be asked to take part in a one-to-one interview lasting approximately one hour. Participation is confidential and anonymity guaranteed.

To participate, or for more information please contact Nicole via email at [nicole.nicholls.1@city.ac.uk](mailto:nicole.nicholls.1@city.ac.uk) or leave a message with your details on: 07770982388 and I will contact you.

You can also visit <http://malesurvivorsofsexualabuse.blogspot.com> for more information.

This research is being supervised by Dr J Farrants, City University, London, ([j.farrants@city.ac.uk](mailto:j.farrants@city.ac.uk)/020 7040 0172)  
Participation in this research is entirely voluntary



## Appendix B – Participant Information Leaflet

Presented as a folded double-sided A4 colour printed leaflet

Will my taking part in the study be kept confidential?

Yes. Ethical and legal practice is adhered to and all information about you will be handled in confidence.

What will happen if I don't carry on with the study/wish to withdraw?

If you withdraw from the study, we will destroy all your identifiable data and this will be excluded from the final write up.

What if there is a problem or I have concerns?

If you have any concerns about any aspect of this study, you can speak to Dr J Farrants who is supervising this research. Her contact details are listed below.

What will happen to the results of the research study?

The results of the study will be used for the researcher's doctoral theses; however individuals will not be identifiable in any report/publication. All participants will be sent a copy of the final report of the results if requested.

### Further information and contact details:

If you would like to take part or require any further information about the study please do not hesitate to get in touch.

Researcher: Miss Nicole Nicholls

Email: Nicole.nicholls1@city.ac.uk

Research Supervisor: Dr J Farrants

Address for correspondence:

Dr Jacqui Farrants

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City University

Northampton Square

London, EC1V 0HB

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*An exploration of the experiences of help seeking in adult male survivors of childhood sexual abuse*

### Information Sheet



#### Experiences of Help Seeking

I am conducting a study on the experiences of help seeking in adult male survivors of childhood sexual abuse (CSA). We are aware that some people may initially find it difficult to seek support for difficulties related to CSA and research demonstrates that many delay help seeking until adulthood. I am interested in your experiences of help seeking and any challenges, barriers or positive experiences of help seeking that you may have experienced. If you feel you would like to take part in this study please read the following information. Before you decide you need to understand why the research is being done and what it would involve for you. This information sheet will explain the purpose of the study and what will happen if you decide to take part. Please note: YOU WILL NOT BE ASKED TO GIVE ANY EXPLICIT DETAILS OF ABUSE EXPERIENCES, however it is possible that you may divulge information about very difficult experiences. All information obtained is confidential and will be kept anonymous.

#### What is the purpose of the study?

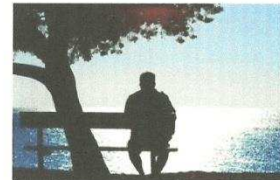
The study aims to investigate, males experiences of help seeking as an adult survivor of childhood sexual abuse. Help-seeking may involve seeking social support, or psychological interventions. The purpose of this is to add to and address the shortcomings of the current research base and provide a comprehensive understanding of the ways in which males decide to seek help in relation to their experience of CSA.

#### What will happen if I decide to take part?

If, after reading the information you wish to take part in this study, you should complete the consent form and return it in the pre-paid envelope. If you change your mind, you are free to withdraw at any time, without giving a reason. If you decide to take part, you will be contacted and we will arrange a suitable time to conduct a semi-structured interview. This interview will take place at City University London and be conducted by the primary researcher. The interview should last approximately one hour, during which you will be asked to discuss your experiences of help seeking. The interview will be recorded using an audio-recording device. The tapes will be transcribed by the researcher. Following transcription of the tapes all data will be coded to ensure anonymity.

#### What are the possible disadvantages to taking part?

We acknowledge that some of the issues under discussion are sensitive, although you will not be obligated to discuss anything which you are not comfortable to, and you are able to stop the interview at any time if you wish.



#### What are the potential benefits to taking part?

I cannot promise the study will help you but you will be given the opportunity to discuss and reflect upon your experiences of help seeking. Future benefits of the research may include the development of a better understanding of the positive and negative impact of help seeking and identify how best professionals and counselling psychologists can support males who seek help. Awareness and understanding could inform further research in this area.

## Appendix C – Consent Form

### Consent Form

#### *The experiences of help-seeking in male survivors of childhood sexual abuse*

Participant Pseudonym: .....

1. I confirm that I have read and understood the information sheet provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving notice. ☐
3. I understand that interviews will be recorded using an audio-recording device, and that anonymised use of my data may be used for verbatim quotation in the write-up of this study. I consent to my interview being recorded and verbatim quotation used. ☐
4. I agree to take part in the above study. ☐

.....  
Name of participant                      Signature                      Date

.....  
Name of researcher                      Signature                      Date

## **Appendix D – Interview Schedule**

### **Interview Schedule**

Thank you for agreeing to talk to me about your experiences. This project is an investigation of the experiences of help-seeking in adult male survivors of childhood sexual abuse. The aim is to increase understanding of peoples experiences of help-seeking and to identify any factors that may mediate or moderate this process.

#### **Consent**

If you are willing to proceed, I would like to record this interview. The recording will only be heard by myself and occasionally by my research supervisor and will be securely stored until the end of the project when it will be destroyed. If you would like me to stop recording at any stage, or you decide after we finish that you would like me to delete the recording and not use it in this research project then please contact me and I will do so immediately. Unfortunately I will not be able to do this after February 2012 when the project will be submitted. If you need to contact me my phone / email are: (give details). If you are happy to carry on, please sign the consent form.

#### **Questions and Prompts**

‘I would like to understand what the experience of help-seeking is like for adult male survivors of childhood sexual abuse. As you might be aware many people often do not disclose sexual abuse or seek help. Learning more about this process will help inform those who work with survivors and hopefully improve practice. I have four broad areas that I would like to touch on, please add anything relevant to your experience that you feel would be useful to know. If you experience any distress at any time and want to stop this is absolutely fine, or if you wish to leave out any of the questions please just say and we can move on to the next question’.

#### **Demographics**

- **Age range**

#### **Help-seeking**

Prompts:



- Have you ever sought any help/support/psychological intervention related to your experiences?
  - Can you tell me about these help-seeking experiences?
  - Consider groups versus individual support – positives and negatives, self-help or professional help?
- (If sought psychological support) What made you decide to ask for psychological support? Did something happen? Symptoms get worse, did someone recommend it? How were you coping at the time?
- What if anything encouraged or discouraged help seeking?
- What forms of help were you looking for?
- Did you associate disclosure with 'help-seeking'?
- Do you think it is harder for males to seek help for CSA? In what ways?
- What was 'the experience' of help-seeking like for you?

### **Disclosure**

Prompts:

- When (if at all) did you disclose your experience of sexual abuse? (How old were you?)
- What was this experience like? (Who to?)
- What made you wait to disclose? (If left until adulthood)

### **If attended therapy**

Prompts:

- How did you feel / what did you think about therapy before you started?
- Previous experience? What did you think would happen? What information did you have? Your & others thoughts about therapy?
- What sort of therapy/psychological intervention did you receive? (Orientation, frequency, length, aims, setting).
- What do you remember most? How did it affect emotions, thoughts, behaviour, physical sensations? Was it difficult to make the commitment to it? Was it worth that commitment?
- What were the negative or less helpful things that happened?

- How easy/difficult was it to develop a relationship with your therapist?
- Did anyone notice any change in you? What do you think changed (if anything)?

If help has not been sought, have you considered any psychological intervention or treatment?

- (If no: thank you for participating in this research. I am aware that it is a big step if you have never discussed this before. What is it like talking about your experience today?
- What help do you think is available?
- How do you feel about seeking help?
- What would make you reluctant to seek help?
- What would make you want to seek help?
- What do you think would be a successful outcome?

### **Impact on your life**

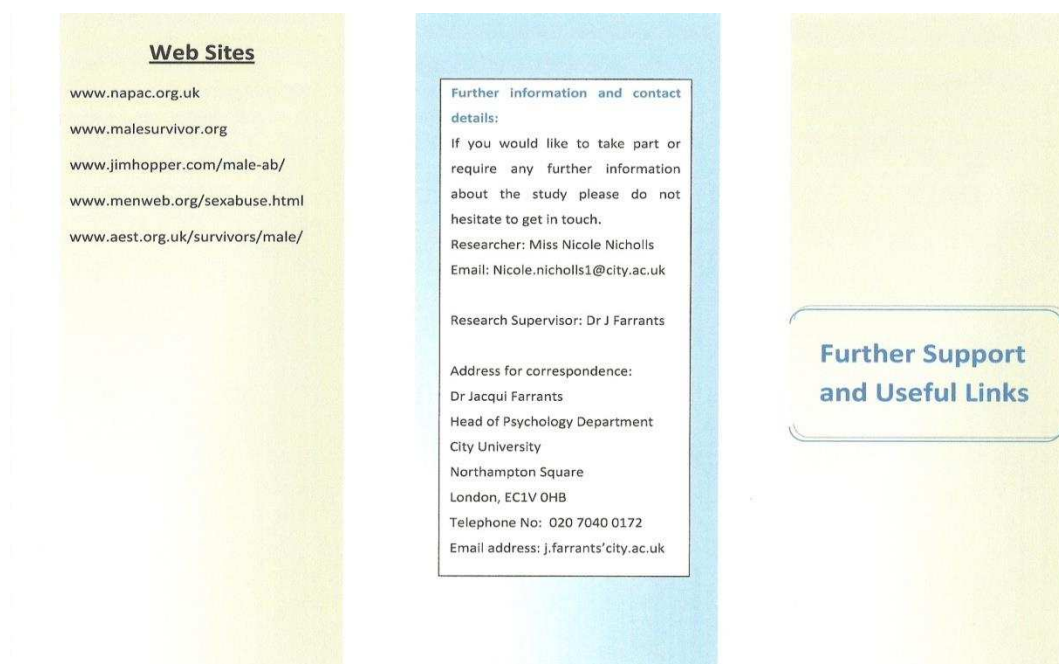
Prompts:

- How do you think your life has been impacted/affected by your childhood experience? As a child, a teenager and an adult?
- What was the most difficult aspect to cope with at the time, afterwards, now?

Is there anything else you would like to tell me?

Thank you for taking the time to talk to me. How do you feel about the experience (check for distress)? Do you have any questions? Please contact with me if you have any questions or want to talk about this interview.

## Appendix E – Resources list – Presented as a folded flyer



Thank you for taking part in this study. It is hoped that this experience will not cause any distress, however If you would like further support, a number of organizations have been listed.

- **NAPAC** - The National Association for People Abused in Childhood. Free phone Support Line 0800 085 3330 ([www.napac.org.uk](http://www.napac.org.uk))
- **AMSOSA UK (Adult Male Survivors of Sexual Abuse) - formerly Swindon Survivors:** [www.amsosa.com](http://www.amsosa.com) - National helpline and support group for male survivors

### The Mankind Initiative:

**01823 334244**

[www.mankind.org.uk](http://www.mankind.org.uk) - National telephone helpline providing counselling, support and information to men with relationship issues, and physical, emotional, sexual abuse.

### Mpower: 01603 667 687

[www.male-rape.org.uk](http://www.male-rape.org.uk) - Help for men who have been raped or sexually abused.

### Survivors UK: 0845 122 1201,

email [info@survivorsuk.org](mailto:info@survivorsuk.org),

[www.survivorsuk.org](http://www.survivorsuk.org) - National helpline offering information, support and counselling for anyone affected by the sexual assault of men.

### Books

- Victims No Longer - Men Recovering from Incest and other Sexual Child Abuse by Mike Lew
- Beyond Betrayal: Taking Charge of Your Life After Boyhood Sexual Abuse by Richard. B. Gartner
- Home Coming by John Bradshaw
- The Survivor's Guide: To Recovery from Rape and Sexual Abuse by Robert A. Kelly, Fay Maxted and Elizabeth Campbell
- Surviving and Moving On: Self-help for survivors of childhood sexual abuse by Kim McGregor
- Surviving Childhood Sexual Abuse: Practical Self-help for Adults Who Were Sexually Abused as Children by Carolyn Ainscough and Kay Toon



Excerpt of Transcript

Appendix F - Annotated Extract from Transcript 1

Significant factors leading to disclosure	prospect of erm... err at least one of my abusers, at least my main abuser who was my brother-in-law... em he would of come to my father's funeral had he been allowed, even though he's not my brother-in-law anymore.... my sister long.. long since departed company with him but he would have come to my dad's funeral and the enormity of what he did to me didn't really hit until my dad was dying and I started to think about things and around about the time when my dad was dying my own children err my young two children were around about the same age, that I was, when my ex-brother-in law started sexually abusing me, I mean I was seven or eight years old and I think the whole thing all just conspired to go there and I needed to find help and my family basically united against me... not in denying that it happened but simply why did I have to bring it up after all these years (laughs) and why did I have to bring it up around dad's death and I don't think they ever had a clue as to the impact of abuse that I, I, think they probably still don't have a clue about the real impact of it... even though they were in some ways involved on the periphery with it because he was a, he was a particularly nasty piece of work erm my brother-in-law... and erm I subsequently found out after my disclosure that he had assaulted other people in our family as well including one of his own blood children, so it wasn't just me that he attacked, it was others... but nobody was prepared to speak out other than me and then.....	Significant event leading to speaking out Prospect of facing/confronting perpetrator Realisation of enormity of abuse and impact Significant event reminding of abused - own children getting to that age Something forcing to seek help/unconscious 'conspiring to go there' Need for help after many years (for family) why now? Why this time? Isolated lack of understanding from family regarding impact Families involvement with perpetrator Disclosure leading others to speak out Not just me he abused, disgust at thought of him abusing his own blood children No one willing to speak out, only me
Awareness of needing help		
Inconvenience to others		
Lack of awareness of the impact of CSA		
Enabling others to disclose		
Enabling others to disclose		

And before that you never even thought of speaking out?

Aware but unaware between past and present - psychological impact I never, no I was always conscious of what had happened to me, but... in a way I never made the connection between how generally down and depressed and lacking in confidence I felt,

with those experiences because as well as sexually assaulting me, my brother-in-law was probably... a very sort of key figure in my life as a child so he came in to my life when I was seven years old so pretty young, and erm he married the, my sister that I adored... and I'm

sure he married my sister partially to get at me... because he kind of got two for the price of one, he had my sister that gave him this, this credibility of marrying a beautiful young woman, which she was and at the same time acquiring her little baby brother... erm Paula my sister was thirteen years older than me, and my brother in law would be twenty two years older than

me... just to give you some time aspect about age differences because you generally assume brother in law is similar in age but he... I was an afterthought in terms of my childhood, err and a mistake as I was often told as a child which is not a good thing to tell a child but again, but erm

yeah I I never really forgot what was done to me, but I never made the connection with how...

Never forgetting what happened Psychological impact I just felt terribly bad about myself all the time and lacked confidence and never thought I'd be any good for anything and, and that was very much what I was told, by him and by others as

Aware of what happened but not making links to current difficulties

Connections between past and present, confidence, depression Not just sexual, significance of person in life (e.g brother in law, family member) Key figure in life from young age Married sister he adored Purpose, married sister to get at him? Intentions, ulterior motives, two for the price of one

Aquired (two for one)

Age of perpetrator

Clarifying age difference of

perpetrator as it might have been

assumed that he was a similar age

I was an afterthought, a mistake,

already unwanted

Often told, development of self-

esteem, unwanted

Never forgot what happened but

didn't make connection between

past and present

Factors leading up to help seeking,

deterioration of mental health and

well-being

Absorbed in childhood, I am no



**Vulnerability factors**

Lack of emotional development or awareness upbringing (vulnerability)

well... because I was in a sort of very abusive circle. My mother was very abusive, verbally, you know emotionally, not so much physically erm... my dad was a strict disciplinarian so I was always afraid of my dad. I wouldn't go, I couldn't talk to my dad...erm I'm not sure I would have been... I mean I wouldn't have even have the words to tell anybody what was happening to me... because I was brought up in a very strict catholic household where the word sex wasn't even allowed through the front door, you know it just didn't exist and, and it was a very, totally repressed kind of household and erm um all the siblings, all my four siblings all experienced that kind of similar oppression if you like, and erm and lack of openness and lack of... lack of real nurturing and love in a way, I mean there was love on one level erm but there wasn't a sort of closeness that families ought to have you know, so I never, so I never told a soul and I only got close to my dad when he was actually dying at which point there was no way I could tell him what had happened. You know it was just too late, and I said to him a couple of days before he died when he was starting to go in to sort of a semi conscious, unconsciousness, I said dad I'm going to sort this family out and he he kind of smiled, I know he didn't really know what I meant in one sense cos I know he never knew what had happened to me, but a couple, another thing that I always share with people was that again a few days before my dad died he said to me, just to me on my own, that he really regretted how he used to hit us when we were children and he said he thinks it was a mistake, and that was incredibly significant moment - father apologising gave courage

Abusive circle, mum abusive verbally, emotionally  
 Father strict  
 Fear as a child, no one ot talk to, no way out of the circle  
 Not having the words (developmental) due to upbringing, strict Catholic) fear of saying  
 Sex - not allowed to be discussed - upbringing  
 word SEX didnt exist  
 Repressed upbringing  
 Lack of openness  
 Lack of 'real' nurturing and love - surface level love  
 Lack of closeness, not having what others have, kept everything inside  
 'Never told a soul'  
 Dad as frail, weak, on death bed, unable to tell him in that state  
 Too late to tell him  
 Wanting to say something...  
 Sorting out, significant point, life and death facing each other  
 Sense of knowing but not knowing  
 Stories he shared about his dad  
 Dad apologising for behaviour, regrets on his death bed for physical abuse  
 Father admitting his mistakes  
 Bravery of father in 'confessing' struck a cord

### Appendix G: Initial Emergent Theme Table for Participant 3

Theme	Sub-theme Ideas	Page & line number
Telling the story	Early experience of 'silencing' learning one should remain silent	P1, L23-24; P2, L17-18 P2, L29-31
	Freedom in disclosure	P10, L25-30
Therapy	Passivity v control	Psychologists as authoritarian – need for collaboration P21, L17-18  Struggle – with someone telling me what's going on in my brain P21, L22-23  Being put off by that – someone telling him what's going on P21, L27  Fears – toxic psychiatry (dangers of theory) P22, L3-16
	Making it possible (time, finances, commitment) (putting life on hold?)	P7, L6-8; P9, L27-33;
	Trying everything	P15, L16
	Fear of dependency on therapy	P18, L32-33
	Collaboration – equals	P8, L15-17
Relationships	Trust n relationships with others	P2, L16; P18, L11-13
	Inability to have romantic relationships – distrust of intimacy	P3, L2-3; P15, L33-34; P16, L2; P24, L19-20
	Developing with therapists 'she/he doesn't understand ' (not hitting the spot) 'you don't REALLY know	P8, L9-10; P8, L10; P18, L3-5
Initiating the journey to seeking help	Inadvertent help seeking	P6, L8-15; P7, L31-33
	I want help / acknowledgement of a need	P4, L21-25; P8, L12-20; P12, L3-4;
	Eyes and ears open (looking out for help)	P5, L25-26; P8, L27-28
	Freedom in speaking out	P8, L26
	Professionals dismissing the issue (pull your socks up)	P7, L14-15;
	Financial aspect to therapy (having to pay)	P8, L6-7;
	Let down by organisations	P17, L1-3
	Spirituality (feeling accepted)	P4, L20-23; P4, L27-29
Displacement as a form of coping	Drugs and alcohol	P2, L18-19; P2, L22-24; P3, L31-33; P6, L24-25
	Education	P6, L6-8; P6, L17; P6, L28;
Loss of self/identity (to cope)		P4, I mean that is you know destroying you know a lot of that and being happy to live in a gutter as a kind of coping mechanism, it was a coping mechanism, a kind of loss of identity and it was a

		coping mechanism....L17-19
Acting out (unconscious attempts to get help?)		P2, L22-23; P2, L33-34; P3, L1-4; P3, L33-34
Therapy	Removing self-blame (learning it's not my fault)	P3, L18-21
No place for men	Feminism	P3, L27-30; P5, L18-21;
	Distinguishing between men and gay men, fear of gay men due to abuse, and learning to re-challenge earlier presumptions	P5, L31-33; P6, L2-5
	Blokes are the problem 'they don't have problems'	P9, L20-22; P20, L10-12
Searching	Searching	P4, L13-18
	Awareness of problem, but not of solution	P4, L13-18; P11, L34; P16, L8-9; P20, L10-12
	Displacement (education) /avoiding therapy	P6, L24-27
Avoiding	'they won't understand the issue'	P4, L31-32
Repairing the self Men as mechanical	Testing the waters - Lifting the lid on the buried emotions	P6, L15-16; P21-23
	The supposed 'curing pill'	P7, L15-19
	Expectations/targets (in therapy)	P8, L11-13;
	Needing something more	P8, L9-10; P13-15; P11, L33-34; P12, L5; P14, L4-12; P17, L7-12; P18, L25-33; P19, L17-19
	Making Excuses	
	Being 'out' as a male survivor – do I want to be in that world the whole time?	P10, L 18-19 P19, L21-22
	Blurting to everyone (expulsion)	P10, L19-20
	Awareness of change in self	P8, L19-20; P8, L27-33; P11, L4-7 & L12-13; P12, L13-16; P12, L26-27; P12, L32; P13, L9-21; P14, L20; P20, L1-3; P24, L9-16
	Being able to make sense	P11, L5-15
	An on-going process	P12, L3-4; P12, L23-24
	Need for self-care (on-going)	P12, L16-19; P16, L20-21; P16, L25-26
	I'm still not fixed /not knowing the answer continuous struggles in life	P11, L23-27 P11, L33-34; P12, L24-26; P15, L28-29; P15, L33-34
	Knowing the answer but can't go there (e.g. body massage)	P14, L15-17
	The lingering impact on current life	P11, L24-28; P12, L30-31; P14, L20-21; P14, L26-29; P15, L23-27; P24, L9-11; P24, L16-19; P24, L19-22
	Gaining knowledge /making sense /measuring progress	P11, 30-33; P14, L30-33, P15, L3-12; P21, L10-11
	Giving up vs. finding strength inner	P18, L12-15



	resources	
	Did all the talking cure stuff /cried it out – stages?	P8, L1-3 P13, L2-4
Awareness of own triggers		P18, L11
Expectations (of him)	Expectations of him in therapy	P10, L4-5
Of others	Protecting others (family / in group – not wanting to dump on them) awareness of others /intolerable	P10, L4-7 P10, L8-11 P10, L20-21; P11, L19-21; P11, L23;
Police	Being taken seriously	P10, L13-17;
Social support	Connecting with other survivors – lifeline	P8, L34-35 & P9, L1-3; P8-13; P9, L17-19; P10, L18-19; P20, L2-4
Lack of support for men	Lack of resources (external) Lack of finances (self)	P9, L26-29
Wounded healer		P 18, L8-10; P20, L13-16
Hindering Aspects		Survivors vulnerability – being drawn in – trying lots of therapeutic approaches People need to know – early sexualisation body responding P22, L 26-29 Untangling the myths about survivors P23, L2-5, perpetrator; P23, L21-22  Being a male and more susceptible to myths – paedo P23, L26-27  Being asked did you enjoy it ‘P23, L28  Feeling gay?  Identity P23, L30-31

## Appendix H – Preliminary Themes table

Theme	Sub-Theme
1) Disclosure	1)Pre (before disclosure ) 2)Peri (during disclosure) 3)Post (after disclosure)
2)Searching (for help)	1)It's like a desert out there – resources 2) The dilemma of being male - Sexuality and masculinity
3) The individual therapeutic journey	1)Relationships (developing, negotiating and managing) 2) Managing problems – men as mechanical - ruptures and avoidance of problems 3)What works 4)Negative experiences of seeking help 5)Wounded healers
4) Making sense and moving forwards	1)The self (making sense) 2)Others (making sense) 3)Recovery as an on-going process

## Appendix I – Author Guidelines from the Journal of Child Sexual Abuse

### Instructions for authors

*Journal of Child Sexual Abuse* receives all manuscript submissions electronically via their ScholarOne Manuscripts website located at: <http://mc.manuscriptcentral.com/WCSA> . ScholarOne Manuscripts allows for rapid submission of original and revised manuscripts, as well as facilitating the review process and internal communication between authors, editors and reviewers via a web-based platform. For ScholarOne Manuscripts technical support, you may contact them by e-mail or phone support via <http://scholarone.com/services/support/> . If you have any other requests please contact the journal at [journals@alliant.edu](mailto:journals@alliant.edu)

All manuscripts submitted to the *Journal of Child Sexual Abuse* must be written in English, APA format, and a maximum of 30 pages in length.

Each manuscript must be accompanied by a statement that it has not been published elsewhere and that it has not been submitted simultaneously for publication elsewhere. Authors are responsible for obtaining permission to reproduce copyrighted material from other sources and are required to sign an agreement for the transfer of copyright to the publisher. As an author you are required to secure permission if you want to reproduce any figure, table or extract text from any other source. This applies to direct reproduction as well as "derivative reproduction" (where you have created a new figure or table which derives substantially from a copyrighted source). All accepted manuscripts, artwork, and photographs become the property of the publisher. In addition, please submit a separate document clearly outlining if: (a) if the author has any financial conflicts of interest, (b) if you have approval from your Institutional Review Board for a study involving animal or human patients, (c) if there are any informed consent notifications to state. Please see: <http://journalauthors.tandf.co.uk/preparation/copyright.asp#link3> for more details.

All parts of the manuscript should be typewritten in Times New Roman font, size 12pt, double-spaced, with margins of at least one inch on all sides. Number manuscript pages consecutively throughout the paper. Authors should also supply a shortened version of the title suitable for the running head, not exceeding 50 character spaces. The title page should also include author address and contact information for correspondence, affiliation, and eight keywords or phrases for abstracting. Headings must follow APA format with bold, italics, and

indentation as appropriate. Each article should be summarized in an abstract of not more than 120 words. Avoid abbreviations, diagrams, and reference to the text in the abstract. Please consult our guidance on keywords [here](#).

**References.** References, citations, and general style of manuscripts should be prepared in accordance with the most recent APA Publication Manual. Cite in the text by author and date (Smith, 1983) and include an alphabetical list at the end of the article.

*Examples:*

Journal : Anderson, A.K. (2005). Affective influences on the attentional dynamics supporting awareness. *Journal of Experimental Psychology General*, 134, 258-281. doi: 10.1037/0096-3445.134.2.258

Book: Weschsler, D. (1997). *Technical manual for the Wechsler Adult Intelligence and Memory Scale - III*. New York, NY: Psychological Corporation.

Chapter in a Book : Chow, T.W., & Cummings, J.L. (2000). The amygdale and Alzheimer's disease. In J.P. Aggleton (Ed.), *The amygdale: A functional analysis* (pp. 656-680). Oxford, England: Oxford University Press.

**Illustrations.** Illustrations submitted (line drawings, halftones, photos, photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

- 300 dpi or higher
- Sized to fit on journal page
- EPS, TIFF, or PSD format only
- Submitted as separate files, not embedded in text files

**Color Reproduction.**

Color art will be reproduced in the online production at no additional cost to the author. Color illustrations will also be considered for the print publication; however, the author will bear the full cost involved in color art reproduction. Please note that color reprints can only

be ordered if the print reproduction costs are paid. Art not supplied at a minimum of 300 dpi will not be considered for print. Print Rates: \$900 for the first page of color; \$450 for the next 3 pages of color. A custom quote will be provided for authors with more than 4 pages of color. Please ensure that color figures and images submitted for publication will render clearly in black and white conversion for print.

**Tables and Figures.** Tables and figures (illustrations) should not be embedded in the text, but should be included as separate sheets or files. A short descriptive title should appear above each table with a clear legend and any footnotes suitably identified below. All units must be included. Figures should be completely labeled, taking into account necessary size reduction. Captions should be typed, double-spaced, on a separate sheet.

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## Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.

### Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc                      M.Phil                      M.Sc                      D.Psych    X    n/a

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

Stopping the Silence: Males experiences of 'seeking help' for Childhood Sexual Abuse.
---

2. Name of student researcher (please include contact address and telephone number)

Nicole Nicholls  
[Nicole.nicholls1@city.ac.uk](mailto:Nicole.nicholls1@city.ac.uk)  
Tel No: 07827293705

3. Name of research supervisor

Dr Jacqui Farrants

4. Is a research proposal appended to this ethics release form? Yes

5. Does the research involve the use of human subjects/participants? Yes

If yes,

8-10

a. Approximately how many are planned to be involved?

b. How will you recruit them?

The study sample will be recruited by (a) via information flyers distributed at events for survivors (In to the Light – March 2011 and October 2011); (b) via the National Association for People Abused in Childhood (NAPAC) Web site; a United Kingdom (UK) helpline charity providing support and information for people abused in childhood; and (c) word of mouth.

c. What are your recruitment criteria?

*(Please append your recruitment material/advertisement/flyer)*

Males who identify themselves as survivors of childhood sexual abuse will be recruited for this study. Participants must be over 18 years old. Male survivors who are waiting to provide evidence in court due to their sexual trauma, and anyone experiencing major mental health issues (e.g., actively psychotic or suicidal) will be excluded from participation in this research for legal and ethical reasons.

d. Will the research involve the participation of minors (under 18 years of age) or vulnerable adults or those unable to give informed consent? No



d1. If yes, will signed parental/carer consent be obtained?      Yes      No

d2. If yes, has a CRB check been obtained?      Yes      No  
(Please append a copy of your CRB check)

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

Participants will be required to participate in a taped interview last approximately an hour to an hour and a half.

7. Is there any risk of physical or psychological harm to the subjects/participants?      No

If yes,

a. Please detail the possible harm?

There is no harm anticipated beyond what they participants experience in their daily lives. It has been considered that taking part in the interview may be a distressing experience due to the topic of discussion however precautions will be taken to minimise these risks of harm.

b. How can this be justified?

It has been considered that further understanding of this phenomenon will advance knowledge on how Counselling Psychologists and other health professionals can support the help seeking attempts of male survivors of sexual abuse. Knowing when and how men decide to seek help may deepen understanding as to how to support those men in the initial stages of help seeking and is a vital step towards understanding what may help or hinder this process.

c. What precautions are you taking to address the risks posed?

The study will be conducted in accordance with the ethical standards of the British Psychological Society (British Psychological Society, 2007). These standards require that participants give informed consent to participation in the study, are assured of confidentiality, be informed of their rights to withdraw at any stage prior to final write up and are protected from any physical or psychological harm or distress.

Participants will be given an accurate description of the study and assured that withdrawal not be detrimental to them on first contact with the researcher. It will also be made clear that the interviews are designed to record information rather than offer any form of psychological intervention. Participants will be informed that they will be asked about help-seeking and will not be asked to divulge any detail of the actual sexual abuse experience. During interviews, it will be necessary to be aware of the possibility of distress and to avoid pursuing difficult topics. Information sheets with local support groups and available resources will also be provided. The contact details of the researcher will be provided to participants in the event they have any questions or concerns about the research prior to and after the interviews.



8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

*(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)*

Yes

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

Yes

No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Interviews will be recorded and transcribed by the researcher. No identifying data will be used and participants will be given pseudonyms so that data is not identifiable.

12. What provision will there be for the safe-keeping of these records?

Files will be stored in a locked filing cabinet and on a password protected PC. No other person will have access to any of the information obtained.

13. What will happen to the records at the end of the project?

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Once data has been transcribed all audio interviews will be deleted. At the end of the project data will be stored securely for a period of time and then shredded.

14. How will you protect the anonymity of the subjects/participants?

Pseudonyms will replace names and all identifying information will be changed or removed from transcripts.

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

Participants will be debriefed after the interviews and given the opportunity to reflect or discuss any concerns at this time. They will also be given the contact details of the research prior to taking part in the event that they have any concerns or questions. Information on support sources for males will be given.

*(Please append any de-brief information sheets or resource lists detailing possible support options)*

If you have circled an item in underlined bold print or wish to provide additional details of the research please provide further explanation here:

CHECKLIST: the following forms should be appended unless justified otherwise

Research Proposal  
Recruitment Material  
Information Sheet  
Consent Form  
De-brief Information

## Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself? Yes

If yes,

a. Please detail possible harm?

There is a risk that the researcher may experience strong emotions or psychological distress on hearing participant's stories. There is also a possible risk of harm to the researcher in the event that the participant becomes angry or violent.

b. How can this be justified?

Learning more about males experiences of help-seeking in adulthood for childhood sexual abuse would enable further understanding of the challenges or difficulties faced in help-seeking and would possibly inform future practice for counselling psychologists.

c. What precautions are to be taken to address the risks posed?

The researcher will ensure that her own safety is ensured by liaising with the University with regards to premises to conduct interviews. Interviews will be held in a public location such as the university and the researcher will inform two colleagues of when and where she will be during the interviews and the anticipated times. A panic alarm will also be available. The researcher will not divulge any personal information apart from her name and contact email.

Risk will be informally assessed over the phone prior to meeting the participants. Before interviews the researcher will ground herself and ensure that she is able to work with the client and the material being presented (e.g. to ensure that no other issues might impact her ability to engage in an interview). After interviews the researcher will debrief the client and again, use a grounding exercise to minimise any distress. Arrangements will be made to discuss any feelings that occur as a result of the interviews in personal therapy or supervision.

It is possible that hearing client's material may evoke strong emotions. It is necessary for the researcher to be aware of this and ensure adequate arrangements for self-care are made – such as arranging personal therapy to follow interviews, debriefing with a supervisor or using relaxation techniques to alleviate any distressing emotions.

**Section C: To be completed by the research supervisor**

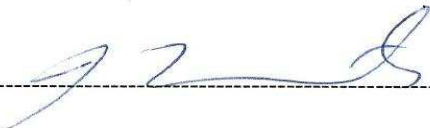
*(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)*

Please mark the appropriate box below:

Ethical approval granted

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature  Date 1/4/11

**Section D: To be completed by the 2<sup>nd</sup> Departmental staff member**

*(Please read this ethics release form fully and pay particular attention to any answers on the form where underlined bold items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above

Signature  Date 6/4/11

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Signature of student researcher  Date 14/4/2011

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## **Part B: Professional Practice**

### **Client Study, Critique and Reflections**

**Reflections and Critique of a First-Year Client Study –  
A Demonstration of Learning and Development in the Journey to  
Become a Counselling Psychologist**

**Introduction**

The following piece of work presents an original client study submitted during my first year of training as a Counselling Psychologist. It described the initial stages of therapy with John, a client who disclosed childhood sexual abuse (CSA) in the content of therapy. This is followed by a 3,000-word reflective critique of the study and discussion of my subsequent learning on the topic of CSA. The names of all persons and any identifying information in this study have been altered to protect the confidentiality of the client.

Re-reading this case two years on, I feel privileged to have met and worked with John, who inspired my journey to want to learn more about this topic area. I hope that our work gave him the experience of feeling understood and supported. At the time of the study, I did not have a vast knowledge of particular interventions and therapy techniques. John taught me a lot about strength and resilience and I consider my work with him an extremely valuable experience both personally and professionally. Throughout my training, I have sought to increase my understanding of the impact CSA can have on an adult's life. As a result of continued engagement with the subject over the subsequent two years through volunteering, providing telephone support to adult survivors of abuse, and choosing to research the experiences of help-seeking in male survivors of CSA for my Doctoral thesis, I feel I have gained an in-depth understanding of the complexities of working with male survivors and the variety of issues that might present in the therapy room. I aim to show how the expanding body of knowledge related to male CSA can be integrated to theory and practice, informing Counselling Psychologists who work with this client group. I will also reflect on how the findings from my research have advanced my understanding of this phenomenon and will be applied to any future practice.



## **Part One: The Original Client Study**

### **Processing a Traumatic Childhood Experience using the Person-Centred Approach - 1<sup>st</sup> Year Assessment**

#### ***Rationale for the Chosen Case***

I have chosen to present the case of John, a client who requested psychological support whilst attending a substance misuse treatment service for help reducing his methadone prescription. The case demonstrates the use of the person-centred approach with John, whose substance use was a means of coping with past trauma. This approach fostered an environment in which John was able to feel understood and begin a journey of change in a safe and supportive environment.

#### ***Theoretical orientation***

The psychology service, based within a National Health Service (NHS) substance misuse treatment service, provides clients with a flexible approach to exploring their difficulties. On starting the placement I was encouraged to begin working with clients using a person-centred approach, with the expectation that I would use supervision to explore the addition of alternative interventions (Cognitive Behavioural Therapy (CBT), motivational interviewing and relapse prevention) following further training.

Person-centred therapy (Rogers, 1957) provides a broad therapeutic orientation which can be applied to the treatment of many different areas of suffering (Sanderson, 2006). Rogers believed that providing a relationship with the presence of three core conditions, empathy, congruence and unconditional positive regard, which offer clients the self-actualising tendency towards growth (cited in Mearns & Thorne, 2007). Empathy refers to the experiencing of the client's world without losing sense of one's own awareness and conveying this to the client. Congruence refers to the therapist being genuine and aware of their own feelings, perceptions and movements, and showing unconditional positive regard involves the therapist accepting the client for who he or she is without evaluating or disapproving of particular feelings, actions or characteristics (Rogers, 1975). The therapist communicates this attitude to the client by a willingness to listen without interrupting, judging or giving advice (McLeod, 1998). Central to the person-centred approach is the view that *'the client knows best; and therefore the client who knows how to move forward'*

(Rogers, 1990, p. 1); therefore, each client is the expert in their own life, and is viewed as being capable of fulfilling their own potential for growth. Another important construct within the person-centred approach is the organismic valuing process (OVP, Rogers, 1951), which refers to one's innate ability to know what is important to them and what is essential for a fulfilling life. An effective therapeutic alliance will lead to the client trusting their OVP and moving towards self-actualisation (Rogers, 1990). The therapist facilitates self-actualisation by providing an environment in which clients can freely engage in focused, in-depth self-exploration.

### ***The Referral***

Following a request for psychological support, John was referred by his key worker to the psychology department. A brief referral letter stated that John had seen a Trainee Psychologist in April 2009 for one session before disengaging.

### ***Convening the First Session***

Sessions were held in the psychology rooms at the service. Prior to meeting John, I was informed that he had previously disengaged after an initial session with a psychologist earlier in the year. I wondered how he would feel meeting another therapist, and what had encouraged him to seek a re-referral to the service at this time. John arrived on time, unshaven and dressed casually. He spoke softly and did not maintain eye contact. His presentation and body language suggested he was nervous and he spoke in short sentences. Mearns and Thorne (2007) highlight the importance of being aware of one's own feelings and thoughts and communicating these to the client, if appropriate. I realised that I wanted John to feel at ease, and to show him that I hopefully would not come across in the same way as the previous therapist he had seen who he found intrusive.

I explained that I was a Trainee Counselling Psychologist, and introduced time and confidentiality boundaries. In line with ethical requirements, I outlined the situations in which confidentiality must be breached (i.e. if harm to self or others), before inviting John to share with me what he was comfortable with about his current difficulties. For the remainder of the session I listened attentively, keeping a mental note of the ways in which John communicated with me.



### ***Biographical Details***

John is a 42-year-old, white British male. He lives alone and worked as a painter until 2005 when he became unemployed. This resulted in the breakdown of his five-year relationship. John's parents separated when he was seven and his father died when he was eighteen. He has two sisters, and two children (aged 7 and 10), both of whom he reported currently having no contact with. John has been on a methadone programme for over a year. He described a long history of substance misuse, which began in his early teens.

### ***Exploration of the Presenting Problem***

Consistent with a person-centred approach, I listened attentively to John, giving him space to share what he was comfortable with. He described the difficulties associated with the reduction of his methadone, including physical symptoms such as being unable to sleep and extreme sweating, and psychological symptoms that alternated between feeling anxious and on alert to mood swings. John also reported experiencing vivid nightmares and had strong cravings to use heroin. Although wanting to become abstinent from methadone, he found his symptoms worsened when doing so. Gaining a thorough understanding of John's problems took several sessions, and as we built up a rapport he began to share more about the experiences that led him to begin taking drugs. He described his childhood as 'difficult', and later disclosed a history of sexual abuse. Empathising with John's experiences led him to share that he never sought any help or told anyone after the abuse occurred.

### ***Tentative Formulation***

John described having to be 'the man of the house' after his father left when he was seven, and grew up with the message that 'boys don't cry', which was evident in his ambivalence about showing any emotion. I wondered if John had developed conditions of worth based on his upbringing, which had been reinforced throughout his adolescence and adult life. John later shared his experiences of trying to tell a female partner that he had been sexually abused during his childhood. However, his partner became abusive and controlling within the relationship, using his disclosure to attack him further, therefore further reinforcing his ideas about not being a 'proper man'. Bass and Davis (1992) explain that if a survivor's feelings are denied or criticised, it may take a while before they feel safe enough to express their feelings again. I was aware that it might take time to build up a relationship in which John felt safe enough to trust me.

After disclosing John found it easier to talk about his current difficulties. In addition to the nightmares he experienced, John described suffering with what he described as ‘absences’. Warner (2000) suggests that individuals who experience early trauma can enter into trance-like states that reduce immediate experiences of trauma, and that clients may move into such states when the original trauma memories threaten to return. This resonated with me from John’s descriptions. He saw these ‘absences’ as separate from himself and was unaware of his actions when in these states. Due to John’s difficulties with relationships, substance misuse and inability to manage his emotions, he began to disengage with the world around him. He appeared to be in a profound state of incongruence; his expectations of himself did not match what he felt they should be. He wanted to be a man and cope with his difficulties, yet his emotions and feelings overwhelmed him and prevented him from doing so; as such, he used drugs to escape from reality. A tentative diagrammatical formulation can be observed in Figure 1.

### ***Therapeutic Aim and Negotiating a Contract***

Following our initial sessions and reaching an idea of the extent of John’s current difficulties, I sought advice from my supervisor with regard to the number of sessions I could offer and whether it would be appropriate for me to continue with psychological intervention with John, considering his difficulties. Mearns and Thorne (2000) suggest that when using a person-centred approach, it is important that both the counsellor and the client agree on a mutually acceptable contract. I discussed this with John in our second session and we initially agreed to meet weekly for twelve 50-minute sessions.

Due to John’s previous reluctance about engaging in therapy, I felt that a person-centred approach would facilitate the foundations of a therapeutic alliance in which John could begin to explore the different aspects in his life affected by his past trauma and the current impact on his ability to reduce his substance use. The therapeutic aim was to provide the core conditions, as described by Rogers (1961), that would facilitate this process, and in doing so, provide a space where ‘between two people, each person is fully real with the other, and able to understand and value the other’s experiences’ (Mearns & Cooper, 2005, p. 13).

### ***The Therapeutic Plan and Main Techniques Used***

The therapeutic plan was to establish a relationship in which John felt safe enough to open up to me to enable him to begin to make sense of his past and ongoing difficulties. In

accordance with the person-centred approach, I did not attempt to diagnose John's problems (Mearns & Thorne, 1999); instead, it was important that John and I explored certain themes that were based on his experiences and individual to John. Rogers proposes that 'when the therapist is experiencing a positive acceptant attitude to wherever the client is at that moment, therapeutic movement or change is more likely to occur' (Rogers, 1980, p. 116). I therefore sought to be 'with' John, and remain consistently accepting towards him (Mearns & Thorne, 2007). It was important to acknowledge the traumatic experience John had suffered and how difficult this was for him. Sexual abuse involves a violation of a client's personal boundaries (Etherington, 2000). It was therefore crucial that boundaries were maintained. Substance misuse had enabled John to cope over the past twenty-five years; however, he reported wanting to be able to move forward in his life without this coping mechanism. It was important to recognise that his substance use had served a function in his life and that reducing his methadone prescription would take time.

In keeping with the person-centred approach, goals for therapy were not set. The person-centred counsellor trusts the work of the actualising tendency to bring to the client's attention, experiences and memories when the time is right for them to be addressed (Bryant-Jefferies, 2003), and when the environment is perceived to be sufficiently supportive and facilitative of this intrinsic need (Rogers, 1959). With this in mind, I listened empathically, accepting John unconditionally and trusting his capacity to discover his own inner resources. I sought to reflect his words, experiences and affect (Carkhuff & Berenson, 1977) and to convey my understanding of his distress, which led to a greater capacity to explore and accept previously denied aspects of himself (McLeod, 1998). I sensed John had internalised a lot of shame, demonstrated by changes in his body language and averted eye gaze. Sharing his views on men (one in particular was '*men don't cry*') highlighted that for John, being emotional was incongruent with his beliefs, causing a constant reinforcement of negative feelings about himself. These were further reinforced by societal views and male gender roles. Using the technique of process direction (Rennie, 1998), John could explore all the parts of his 'self' (Mearns & Thorne, 2000), including incongruence arisen from denying certain aspects of self as a result of his internalised beliefs.

### ***Key Content Issues within the Therapeutic Process***

Key content issues included developing trust to facilitate an effective therapeutic alliance, exploring John's ambivalence about therapy and considering new ways of coping with the

ongoing symptoms he experienced in relation to his past trauma. During our first session, John revealed that the previous therapist he had seen had been intrusive and too questioning. At this point I became very aware of my responses and the importance of giving John space to feel comfortable enough to work with me.

John's disclosure process was considered a key aspect of treatment. I had a sense that there were underlying difficulties from John's presentation in his initial sessions. After sharing that he experienced problems during his childhood he was silent for a few minutes. I felt the need to respect the silence and waited a while before gently asking John if he was ok. His reply was *'I'm not sure how much to say about anything' how in-depth do we go here'*. I explained that I was there to listen to what he had to say and he could talk as much or as little as he felt comfortable with. Bowing his head, John mumbled that there had been *'some abuse'* until the age of 14. His face crumpled with emotion, and again I remained silent, leaving him to decide if he wanted to continue. I sensed his discomfort, which was visible as he put his handkerchief across his face whilst saying *'I don't know what to say, where to start'*. John glanced at me and gave an embarrassed laugh. I empathised with his discomfort and told him that sometimes being able to talk in a safe environment helps to process some of the feelings relating to past events, leaving it up to him to decide how to proceed.

John was uncertain whether to explore the experience and his feelings about his past sexual abuse further; this was illustrated to me by his tentative questions. As a person-centred approach was used, sessions were non-directive and used to facilitate John's exploration of his chosen areas in each session, allowing him to control the pace and direction of therapy. Building a trusting relationship is a significant factor in enabling the development of a therapeutic alliance conducive to change. Sanderson (2006) suggests that the therapist must keep in mind the natural disinclination of survivors of sexual abuse to trust and understand that building therapeutic alliances may be challenging. I ensured that I was consistent in my approach, keeping boundaries and being honest with John at all times.

As our therapy sessions progressed I felt that John opened up, talking in more depth about the impact of his past experiences and the difficult situations he had experienced. We spent time reflecting on his relationships with others, an area John struggled with. I feel I became attuned to the subtle ways in which John tentatively approached topics he wanted to share; for example, he would mention something then quickly change the subject, often with his

head bowed, before looking up out of the corner of his eye to gauge my reaction. I mirrored his pauses and made eye contact to show I was listening, occasionally nodding to demonstrate my understanding, without pushing him. It seemed that John wanted to process his past experience but did not know how, and I felt this should be at his own pace. He approached the subject of his abuse in each session and I found it useful to pay attention to his non-verbal communication. He leant forward slightly if approaching a difficult topic and his speech would slow down, as if screening his thoughts before sharing them. At these times, the pace of the session slowed down, and the silence was full of emotion. I remained in his frame of reference, 'being with' him when he could not find the words to share what was going on for him. Using process identification (Rennie, 1998), (for example, '*I noticed you slow down there, what's going on for you now?*'), I encouraged John to explore what he was experiencing in the session at that time, enabling him to reflect on his feelings. I learnt that if John wanted to discuss a particular topic, he would communicate in a particular way, for example, by asking questions. One example of this was '*what effects does sexual abuse have on young boys*'. I explained that the effects are different for every survivor, and I was able to list a number of different effects that have been highlighted in the existing literature as being associated with CSA. John picked out '*feeling as though they are gay*' and was then able to describe his confusion about his sexuality, his feelings about thinking he was gay in his adolescence, and how he actively sought out relationships with women to convince himself that he was not gay. It was important to normalise these feelings, which are common reactions in survivors of sexual abuse, leading John to consider himself in a different light, encouraging a shift in his organismic valuing process.

As our therapeutic relationship developed, John was able to share his emotions about what had happened to him more easily. It felt as though we were searching for meaning together. This has been recognised as an important feature of coping with the traumatic experience. Taylor (1983) describes making meaning as 'an effort to understand an event: why it happened and what impact it had' (p. 116). A common belief in both male and female survivors is that they hold themselves responsible for having been abused (Vander May, 1988, cited in Yarrow & Churchill, 2009). This resonated with John as he was thirteen when the abuse started, and therefore felt that he should have been able to prevent it. Paraphrasing John's words led him to hear his thoughts verbalised '*you feel as though you are to blame*', and explore his thoughts about his involvement in the abuse. Reflection of John's words was also an effective intervention '*I was just a child*'; my response '*a child*' said with a

slightly stronger tone and a nod to emphasise that John was not to blame. This was my intention and I felt that John understood me, shifting his locus of evaluation from internal to external and beginning to consider that he might not have been at fault.

As a bond of trust grew between us, John allowed his emotions to emerge in my presence. At the same time, I was congruent with my feelings; I showed anger at his mistreatment, sharing a genuine expression of how I was feeling in that moment. This led John to consider his incongruence, the suppression of his emotions and allow himself to cry, processing his previously denied feelings within the therapeutic alliance.

### ***Changes in the Therapeutic Plan***

John explained that he relied on the use of methadone to self-medicate for symptoms associated with his past trauma; therefore, before reducing his prescription he would have to develop alternative methods of coping. Although he had not used on top of his prescription for the past six months, he reported cravings to do so when feeling low or suffering with nightmares and persistent memories of the abuse. He described these episodes frequently re-occurring. My role as a therapist was not to encourage John to stop methadone use, but to support him to develop insight and understanding into his drug use to enable him to achieve his goals. As such, we incorporated a weekly review of his methadone reduction plans and progress. We then used the remainder of the sessions to explore John's emotions relating to past events and consider interventions that might enable him to process his memories in order to move forward. Due to John's difficulties with trust, it was essential to spend time developing this before introducing techniques and interventions. By remaining congruent with John and showing unconditional positive regard, he has been able to reflect on some of his internalised beliefs within the safety of the therapeutic alliance.

### ***Difficulties in the Work and use of Supervision***

After our initial sessions and John's subsequent disclosure of childhood sexual abuse, I sought supervision with regard to ethical practice. I questioned whether I should be working with John, wondering if it would be more beneficial for him to see someone more qualified. My supervisor encouraged me to discuss my feelings of feeling incompetent, and by doing so, gave me the confidence to work with John. We also discussed the use of a person-centred approach and I was pointed in the direction of literature on the subject. I was aware of working within my limits as a Trainee, and felt confident that I could seek support or

supervision when I needed it, which helped me contain my anxieties about being a 'good enough' therapist. At times, I found it difficult to observe John's intense state of helplessness and distress, and as he began to process some of his memories and share more with me, I ensured that I reflected on my feelings outside of the sessions during supervision and personal therapy.

### ***Evaluation of the Work so Far***

John is still attending therapy, and although the process is slow, small changes are evident; John is now able to look at me when sharing his experiences, rather than bowing his head to hide his emotions. Mearns and Thorne (2007) suggest that before seeking help, the client is using self-protective measures to avoid the pain. During the therapeutic process, those barriers are slowly broken down so that the client is experiencing what they have been denying themselves. So far, it is evident to see that John has begun to explore his feelings and is becoming more comfortable in sharing his experiences. In addition, John's organismic valuing process (OVP) has slightly shifted towards accepting himself and valuing his strengths. After our fourth session, John cancelled two of his appointments. I sent him a short note offering him another appointment, wanting him to know he could return if he wished, and that I respected his ambivalence about engaging in therapy. He returned and explained that Christmas was always a difficult time for him. I was glad John had returned and saw this as a positive sign that he has made a tentative move towards processing some of his feelings regarding the abuse, illustrating a shift in his OVP.

At times, I questioned my therapeutic approach, as differing views are presented in the literature on treating survivors of sexual abuse. Edwards and Lambie (2009) recommend the use of person-centred counselling as an effective treatment modality for female survivors; however, Sanderson (2006) notes that although the person-centred approach is more flexible than other approaches, some adult survivors find the lack of structure and unpredictability anxiety-provoking. I was mindful of this and discussed my thoughts with my supervisor.

### ***What I Have Learnt About the Psychotherapeutic Practice and Theory***

My hope to help John overcome his difficulties led me to review the vast yet often confusing and contradicting literature on CSA. A valuable concept I learnt about was the idea that the long-term effects of CSA can be seen within a betrayal-of-trust framework in which the survivor is unable to trust him or herself, others or the world. This reassured me when I had

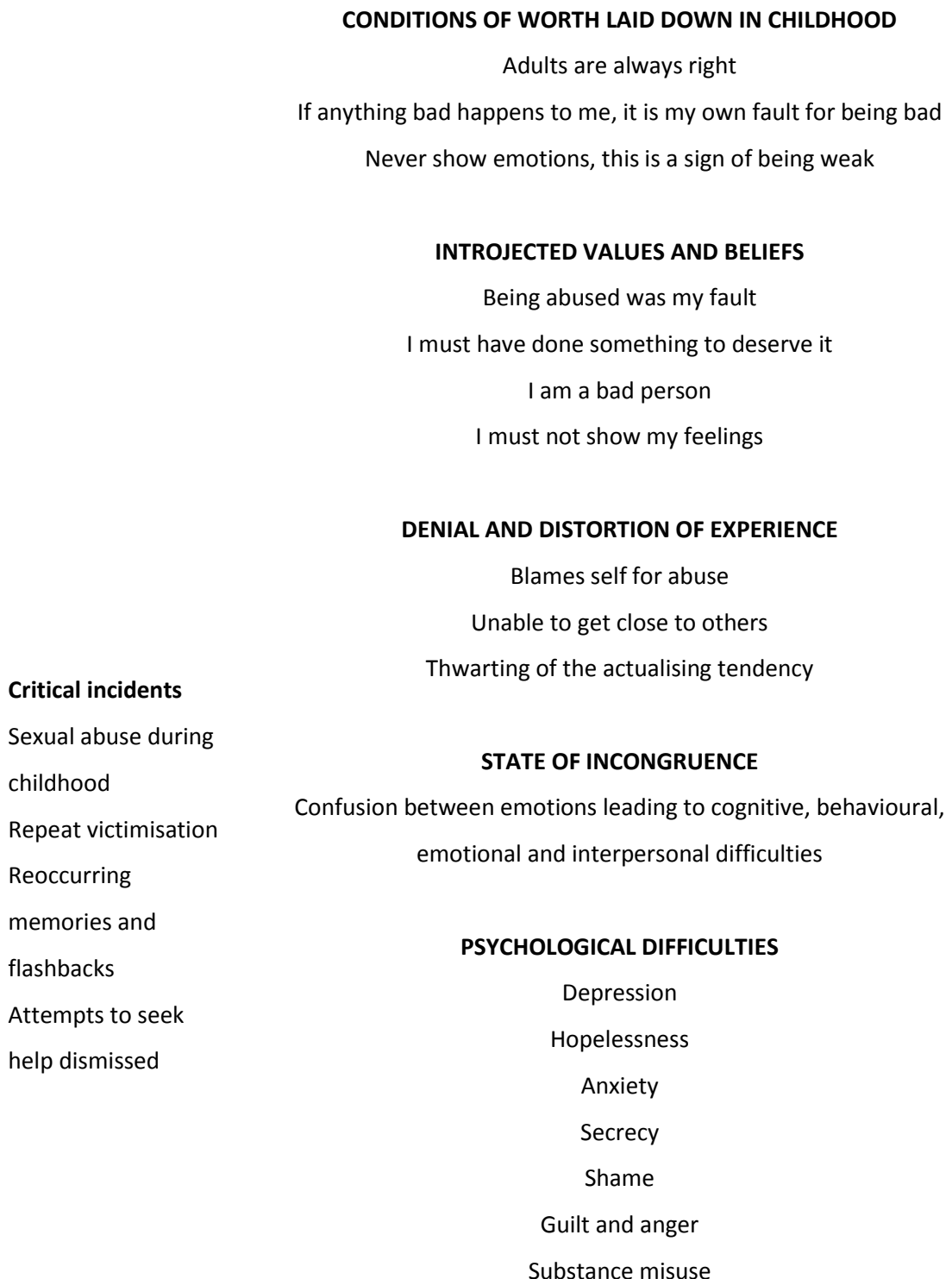
doubts about my competence as a therapist, which were triggered by John's intermittent attendance. I realised that he needed time to develop his trust in me; consequently, I sought to provide a safe therapeutic environment. From the literature I was aware that many survivors may resort to substance misuse to manage overwhelming feelings and dissociative states (Sanderson, 2006). This helped me to understand the context of John's substance use and respect this as his method of coping. Researching the topic of CSA also helped me to understand John's behaviours; for example, a lack of control and powerlessness inherent in CSA may lead to the development of coping mechanisms that can be described as hyper-arousal (a constant state of alertness to prepare for sexual assault), which may continue into adulthood. As a result, survivors have an elevated stress response which effects affect modulation; as such, a survivor may be unable to regulate his or her emotional and physical states of arousal, which invokes defence mechanisms such as numbing and dissociation. This was evident in John's symptoms and descriptions of his 'absences', and having this knowledge enabled me to provide psycho-education to normalise his experiences. The use of a person-centred approach enabled John to move at his own pace, highlighting that the presence of the core conditions and development of a therapeutic alliance are sufficient to enable the client with the agency for movement towards change. At times, I questioned my ability and the effectiveness of my interventions; however, I placed my trust in the approach and its process and the knowledge that '*the client knows best*' (Rogers, cited in Mearns & Thorne, 2005).

### ***Learning From the Case about Myself as a Therapist***

Reflecting on the experiences John shared with me, I found myself imagining the traumatic experience he has lived with for over twenty-five years. Sanderson (2006) notes that whilst a counsellor must prepare themselves when working with a survivor by reading firsthand accounts of sexual abuse situations, it is not the same as being with a survivor face-to-face. I realised the importance of never assuming one wants to move in a particular direction or talk about the abuse, but to be with them, and experience the feelings as they are occurring for the client in the here and now. I found that believing in the process of the therapeutic alliance led John to share with me what he felt comfortable with. I recognised my desire for John to trust me; however, I was aware that this was my agenda, and something I could not control. As such, it was important for me to regularly reflect on my interventions, as well as my feelings about John during and after our sessions, to ensure I continued to work ethically with him.



**Figure 1: Tentative Formulation of ‘Johns’ Difficulties embedded within a Person-Centred Theoretical Framework, as described in Simms (2011).**



## **Part Two: A Critique and Reflections of the Original Study - Two Years Later**

### ***Brief update of work following submission of case study***

I continued to work with John for over a year; during this time, we explored John's complicated history of traumatic events and the maladaptive coping strategies he had developed which appeared to maintain his suffering. John engaged well in therapy and was able to gain some insight into his current problems. We worked on John's self-blame in relation to his past, a key issue for him in that he felt he should be punished for events which he had no control over. Despite exploring an alternative view of his situation, his ideas remained fixed for some time and he continued to describe negative thoughts about his role in the abuse, especially when feeling low. As we approached the end of our sessions, John requested further support. The psychotherapy service I contacted was unable to offer sessions and instead suggested a referral to the local Improving Access to Psychological Therapies (IAPT) service. This was discussed with John; however, his ambivalence was evident, with him agreeing to the referral, and then later changing his mind. I provided him with details of support organisations for survivors of childhood abuse and he appeared keen to explore these options in his own time.

### ***Engaging with the Topic – The Development of Knowledge and Impact on practice***

My development as a Counselling Psychologist has advanced as a result of my work with John and my subsequent research with survivors of CSA. With John, my desire to help him overcome his difficulties led me to research to try to find 'the right' techniques to use during sessions. Counselling Psychologists adopt a reflective practitioner approach drawing on understanding from formal psychological inquiry whilst maintaining firm values grounded in the psychotherapeutic relationship between practitioner and client (British Psychological Society, Professional Practice Guidelines, 2009). This enabled me to constantly reflect on my work, and the therapeutic relationship I developed with John. Whilst training, a diverse range of approaches are introduced, and reflecting on one's use of these is essential to improving knowledge and practice. Furthermore, the values of Counselling Psychology are embedded in this client study. The concept of hearing a person's story, rather than treating a disorder, is paramount. Counselling Psychologists respect the personal subjective experience of the client and aim to help clients better understand and explore their difficulties. Although Counselling Psychologists understand diagnosis and the medical context to mental health problems, this is not the whole focus. Instead, both client and therapist work collaboratively

with an individually tailored psychological formulation of an individual's difficulties to improve psychological functioning. Counselling Psychologists hold a humanistic value base and are focused on understanding the subjective world of the self and other (Strawbridge & Woolfe, 2010). With this in mind, I viewed John as having the inner resources to help himself, and with time and support, he was able to make small changes and move forwards in his life. The collaborative aspect to our work together helped John realise that we were working together, dispelling his ideas about power dynamics, and the ability to be flexible, and work with his choice of material each session enabled him to regain some control in his life. Counselling Psychologists facilitate the emergence of experiences and affect in the therapy room, enabling clients to work through difficulties within the safe limits of the therapy hour. This was important for John, who needed to explore his emotions in a safe and contained space. It was important to provide the time for John to understand his internal world, including his emotions and perceptions of himself, and to gradually empower him to make changes in his beliefs (such as 'it was my fault') and behaviours (taking drugs when feeling down).

Re-visiting my work with John, it is apparent that he experienced multiple psychological difficulties in relation to his earlier experiences of sexual abuse. When we began therapy sessions in 2009, I had not previously worked with survivors of CSA and I was keen to learn how to provide support. Reflecting on this in supervision raised the question 'who's doing all the work?' I realised that a client sets their pace, and their journey must be their own, not my vision of them 'getting better' or overcoming their past traumas. As a Counselling Psychologist, I was able to view John's difficulties from multiple angles and used my knowledge to consider how best to work with him. I learnt that, at times, clients will relapse or leave therapy because processing traumatic experiences is often a difficult and challenging process and this is not a reflection on me as a therapist. This resonated for me when listening to the experiences of the male survivors of CSA that took part in my research, where each individual shared their own unique journey of seeking help, and I learnt that much of the work has to be done by the client, when they feel ready. I am now more aware of bracketing my own ideas about 'recovery', 'healing' or 'getting better' and in future will ensure that I support clients' own methods of moving forwards.

Sanderson (2006) notes that working with survivors of CSA can be emotionally challenging for the therapist and advises that it is essential to have a satisfactory support network and

adequate supervision in order to regenerate depleted resources of energy and emotion. This has relevance to both my work with John and my research exploring the experiences of help-seeking with male survivors. As John described the trauma from his past, I often felt emotional and at a loss of how to help him. Several years later, when listening to the experiences of my participants during my research, these emotions resurfaced. Despite extensive reading on the topic and hearing of traumatic experiences whilst working on the telephone support line, I found it important not to presume anything and to show each participant that his experiences were significant and unique by listening and respecting them as individuals. This is something I also endeavour to apply during therapy. In addition, it is imperative for me as a Counselling Psychologist to be aware of the huge variation in the context of CSA and the impacts on the individual's life. During my work with John, I realised that he was aware of his needs and I wanted to have the opportunity to respond to what is present for him, rather than enforcing my own view about what he might need. Some years on I feel more knowledgeable about containing these feelings in myself as a therapist and sharing these with the client where appropriate. In exploring the literature, I found that there is no straightforward approach to addressing the difficulties associated with CSA, and although there is literature available suggesting guidelines for treatment (e.g. Cloitre, Cohen & Koenen, 2006; Draucker, 2000; Etherington, 2000; Kennerley, 2009), these offered no clear evidence for effective intervention. Volunteering in a support service enlightened me to the variety of different approaches and interventions used in practice and the complexity of difficulties experienced by male survivors of CSA. The courage to begin a journey to explore one's traumatic past has no set outcome and there are no guaranteed approaches to overcoming the experience of CSA.

From my research findings I consider now that John may not have realised what support he needed, so whilst my aim is not to impose a particular journey through therapy, survivors may benefit from information about the variety of approaches and interventions that may help in working on their particular difficulties. Like John, several of the participants in my research had not made the link between earlier experiences of abuse and their current psychological difficulties. Others struggled to share the difficulties they experienced, due to the feelings of embarrassment or shame. Providing information and psycho-education helps to raise questions that survivors may have but are unable to verbalise or articulate.

### ***Reflecting on the Use of the Person-Centred Approach***

Mills and Daniluk (2002) suggest that clinicians treating CSA have tended to embrace more directive approaches, emphasising the provision of instructions, recommendations and explanations designed to promote effective coping, aiming to encourage more adaptive behavioural responses. However, more directive approaches may lead to clients who have a history of CSA feeling hopeless, helpless and possibly retraumatized, because these clients often enter counselling with difficulties related to such issues as control, trust, safety and interpersonal relationships, as found by McGregor, Thomas and Read (2006) in a sample of females. My research findings also contribute to the evidence in finding similar amongst males.

Within a person-centred approach, clients have a voice and become active agents who facilitate their own change and healing. In addition, the client leads and makes decisions about their treatment direction, providing an opportunity to regain control, confidence and self-esteem. Person-centred therapists do not adopt the view that there is a need for specific treatments for specific disorders (Joseph & Worsley, 2005); however, as a Trainee Counselling Psychologist, I was able to consider John's difficulties from a variety of different approaches. It is possible that John may have benefited from trauma-focused Cognitive Behavioural Therapy and he would have met the criteria for post-traumatic stress disorder (PTSD) based on his symptoms. Instead, our therapy work was client-led, with John deciding what he would like to focus on each session. I was aware that a person-centred therapist would not encourage a client to share their history; however, I felt that the approach would enable John to explore what was present for him during the sessions and the meanings he associated with his ongoing difficulties. From my engagement with the literature, I am aware that many men are reluctant to disclose CSA (Finkelhor, 1990; Elliott, 1997); therefore, some enquiry on the part of the therapist may be needed. This view is supported by findings from my research which illustrated the difficulties men have in disclosing and speaking out about past sexual abuse for a variety of reasons. Fear of stigma, shame and embarrassment were described as factors in remaining silent, as well as the feeling of blame for not being able to stop the abuse occurring. John struggled with the aftermath of CSA, which significantly impacted the development of his self-concept. He blamed himself for the abuse occurring, believing that he should have stopped it. I also found this to be the case in my research study. It is therefore of importance to spend time in therapy working on these beliefs to encourage the survivor to

let go of the self-blame and shame associated with thinking they are responsible for the abuse.

The use of a person-centred approach offered John the opportunity to talk about his experiences, consider alternatives to his beliefs and process his memories in a contained space, and in doing so, supporting him to reach a place where the abuse could become part of his past, not his current life. When working with John, I found it difficult to understand how he continued to blame himself even after we seemed to make progress. Therefore, the use of creative interventions such as me standing on a chair, with him crouching down (as if a child), might have been more useful in illustrating the power dynamics of abuse, rather than mirroring John's words and encouraging him to reflect on his feelings. From my research, I am now aware of the difficulties survivors faced in overcoming such deeply held beliefs about their role in the abuse and would consider the use of more active techniques, such as the 'empty chair' technique from Gestalt therapy, or using more concrete intervention, such as asking a client to draw an image of a man and then a boy and drawing the distinction between size and difference in power between adult and child to facilitate a discussion about blame. Both of these interventions were described as helpful by participants in my research study.

### ***Providing Flexibility in Therapy***

Rogers proposed that individuals possess resources of self-knowledge and self-healing, and that personality change and development is possible if a definable climate of facilitative conditions is present (Rogers, 1957). Looking back at my work with John, I wonder if someone can be so rigid in their beliefs that their capacity to build on this self-knowledge for healing might be challenging or unsuccessful. Several of the participants in my research described similar rigid beliefs which impacted their engagement in therapy and the development of an effective working relationship with a therapist. Therapists who allowed the space for participants to explore these beliefs, or the overcoming of ruptures during therapy, were considered as more helpful than therapists who challenged or dismissed the rigid beliefs held by survivors.

The participants in my research discussed the negative aspects of engaging in short-term therapy and difficulties in developing a therapeutic relationship. I was fortunate to have worked with John for over a year, and could be flexible with our sessions. However, I

recognise that in my current place of work (IAPT), this would not be possible. In hindsight, my way of working could be criticised for lacking adequate boundaries with regard to committing to sessions. Furthermore, it is not my contention to suggest that brief therapy is not suitable for all survivors of CSA as some may well benefit from focused work. In my subsequent work with clients with CSA, I have had to decide between offering short-term focused work or referring to more appropriate services, recognising my own limits in terms of what I can offer depending on the requirements of the service and what the client needs.

Whilst working with John, I used a person-centred approach, and as he became more comfortable with me, I shared with him some of the material I had read on the interventions used in therapy with survivors, offering him the chance to try different techniques. We embarked on the process of learning together, which I felt encouraged him to try different ways of coping. One research participant shared a similar experience of working with a therapist who was honest about their lack of experience in working with survivors and they both agreed to read a self-help book together. He found this to be more effective than his work with previous therapists who he reported had claimed to be 'experts' in working with survivors of CSA.

In exploring the literature, I found that a variety of therapeutic approaches have been used with female survivors, including CBT (McDonagh et al., 2005), individual and group therapy (Kessler, White & Nelson, 2003) and psychodrama (Meekums, 2000), yet research with males is limited. Crowder (1995) presents a four-stage treatment model for male survivors, suggesting therapeutic tasks for each phase, e.g. inner child work during the victim stage, and Friedrich (1995) proposes the use of an integrated model borrowing techniques from three theoretical perspectives: attachment theory (Alexander, 1992), behaviour/emotional regulation (Dodge & Garber, 1992) and self-perception or development (Crittenden, 1994). The integrated model subsumes the traumagenic factors, information-processing and the PTSD models and provides an additional developmental and family context. The traumagenic factor of betrayal has both psychological and behavioural effects, including distrust of others and an impaired inability to form close relationships. In addition, the traumatic nature of CSA affects a child's ability to regulate his emotions, thoughts and behaviours, leading to some of the specific symptoms outlined in the PTSD and information processing-models. An integrated model would have been useful in working with John, enabling us to work on his inability to regulate his mood and emotions and his dissociative symptoms, and his difficulties

developing and maintaining relationships with others. Regardless of approach, existing research and the current findings from my study show that an effective therapeutic relationship and the therapist being willing to listen to the client are key factors in effective treatment (Briere, 1989).

### ***Linking my Research Findings to Practice***

As a result of continuous engagement with the topic of CSA and my research into the experiences of male survivors in help-seeking as adult survivors of CSA, I have gained a broader understanding of the range of issues that may present in the therapy room that are unique to male survivors. These include feelings of homosexuality, thinking that the presence of an erection or ejaculation implies consent or enjoyment and fears that others think that they might have gone on to abuse others. I had read about the physical response of the body whilst working with John and felt it important to discuss this. He showed his embarrassment in talking about such things, demonstrated by his averted eye gaze; nevertheless, I felt it important to explain that physiological responses are a natural response and did not mean that the experience was enjoyed or wanted.

My work as a volunteer helped me to realise the complexities of the trauma experienced by many survivors of CSA, and the courage it takes to speak out as an adult and begin to address some of the associated long-standing difficulties. Male survivors experience stigma in speaking out about having been sexually abused due to issues surrounding masculinity and sexuality. From my research, I am aware of the detrimental impact caused by not responding appropriately to a client's disclosure of CSA and feel strongly that health professionals must be aware of just how important it is to provide a safe, supporting and non-judgemental response to their clients' disclosures. Herman (1992) states that survivors of childhood abuse are frequently misdiagnosed and mistreated in the mental health system, and because of the number and complexity of their symptoms, their treatment is often fragmented and incomplete. Although John had not previously disclosed his experience of CSA, he spent many years trying to overcome his difficulties with substance misuse, which was his coping mechanism. The participants who took part in my research also described difficulties in receiving appropriate support and felt their problems had been minimised, which left them feeling as though these were not serious enough to warrant help. As a result of this, several participants shared the barriers they encountered in developing relationships with therapists and other professionals.



Herman (1992) suggests that survivors can become engaged in ongoing, destructive interactions in which the medical or mental health system replicates the behaviour of the abusive family (p. 123). The view of the therapist as an expert was also considered to hinder the development of a therapeutic relationship. I found this resonated in my work with John as he expressed hostility to those in authority, for example, the psychiatrist who prescribed his medication. I feel these dynamics did not impact our therapy because he was aware that I was a Trainee, and therefore he may have felt we were more equal. My work with John and my research findings have emphasised the importance of having an awareness of how the therapist might be perceived by a client and not claiming to be an expert.

I also became aware of the importance of trust in developing a therapeutic relationship with survivors of CSA from listening to the accounts of the participants who shared their experiences of therapy. In many cases, victims of child abuse know or are related in some way to their abuser who takes advantage of the trust placed in them. The majority, like John, had been let down by family members and had been betrayed by their abuser; as such, trusting others was extremely difficult for them. I learnt that a therapist must keep in mind the natural disinclination of survivors of CSA to trust and understand that building therapeutic alliances may be challenging. Elmon and Lingg (1996) suggested that trust be addressed directly and that the therapist might even invite the client not to trust the therapist until the client is ready. Such an invitation is intended to convey an understanding of the client's previous history of betrayal. Elmon and Lingg further emphasised the importance of consistency and stability across the life of the therapeutic relationship.

### ***The Need for Further Research***

Research and support services for females continue to outweigh those for males, despite increased public interest and recent campaigns for male survivors of CSA. Although research is slowly advancing, recently published studies (e.g. Chouliara, Karatzias, Scott-Brien, Macdonald, MacArthur & Frazer, 2012) continue to emphasise the need for improved service delivery and availability of support for male survivors. During my work with John in 2010, I became frustrated at the lack of support services which I could refer male clients on to. Similar frustrations were expressed by the participants in my current research study. Men continue to experience difficulties in finding help and support when they needed it, which often left them feeling even more isolated and that their issues were not important or worthy of help.

### ***Conclusion***

Re-reading John's case two years on has emphasised the significance of reflecting on my practice, considering and challenging the literature and considering ways to improve and develop the service I provide to my clients. The original client study highlights the importance of providing a supportive therapeutic relationship, within which a client can begin to process their difficulties, and as found in existing research, the view that the theoretical approach or qualification is less important than empathy and skills in the practitioner (Havig, 2008). From initially wanting to know how to use the many approaches and techniques as a first-year Trainee, I have come to realise that adopting specialist techniques is not necessarily in itself sufficient. An atmosphere of safety, trust and receptiveness to any form of therapy cannot be established unless professionals are able to show the qualities of empathy, genuineness or respect which survivor's value and have been described in existing research. Briere (1988) states that techniques cannot substitute for the stable, affirming client/therapist relationship based on mutual trust, and this is demonstrated in my work with John.

Willingness to listen to the needs of male survivors is essential so that any specialised help they require can be identified and tailored, leading to the development of an individualised formulation or treatment plan. In addition, the wider social contexts must be taken into consideration so as to enable an environment that empowers the individual to work towards their own goals. Issues particularly relevant to male survivors have been discussed in this case study and it is imperative that practitioners take into account the unique experiences of men, enabling them to explore their difficulties. To conclude, Counselling Psychologists, with their diverse backgrounds in training, can offer flexibility in approaches, responding to the individual needs of men, empathically respecting their accounts as valid in their own terms and working collaboratively to empower them to improve psychological functioning and well-being, utilising interventions from a variety of frameworks at different stages in the healing process.

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## Part C: Publishable Paper

**'It's like pus coming out of a bad wound'**

### **Experiences of Disclosure in Male Survivors of Childhood Sexual Abuse**

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Suggested short title: 'It's like pus coming out of a bad wound'

Key words: *Males, childhood sexual abuse, disclosure, interpretative phenomenological analysis.*

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## **Abstract**

A vast amount of literature explores the impact and experiences of female survivors of sexual abuse. Studies addressing the experiences of males have been slower to emerge, despite estimates that 16% of men have experienced some form of sexual abuse (Finkelhor, Hotaling, Lewis & Smith, 1990). Many studies have documented the detrimental physical and psychological outcomes associated with childhood sexual abuse (CSA), however men are still largely reluctant to disclose CSA and seek help (Alaggia, 2004; Holmes, Offen & Waller, 1997; Sorsoli, Kia-Keating & Grossman, 2008). Understanding men's experiences and elucidating in greater detail how male survivors seek help for CSA in adulthood, including any barriers that may have been encountered, has important clinical implications.

This paper reports data from semi-structured interviews with seven male survivors of CSA analysed using Interpretative Phenomenological Analysis (IPA), offering the reader an insight into this much-neglected area. Analysis established four super-ordinate themes; the first of these, 'Disclosure', is presented in this paper, which illustrated key dynamics for consideration when responding to disclosures of male CSA. Understanding these experiences, including the potential barriers to disclosing CSA, will advance knowledge and enable health professionals to better support this client group. Suggestions for improving psychological support and ideas for further research are provided.

## ***'It's like pus coming out of a bad wound'***

### **Experiences of Disclosure in Male Survivors of Childhood Sexual Abuse**

#### **1.1. Introduction**

Investigations into the nature, prevalence and treatment of childhood sexual abuse (CSA) have emanated to a vast amount of research. Much of this focuses predominantly on female survivors, their experiences, coping mechanisms and therapeutic processes (Holmes & Slap, 1998). Although this offers insight and aids understanding, the extent to which findings can be extended to male survivors is questionable. Wilkins (2010), notes that relatively little attention has been paid to the psychological functioning of men, particularly in the United Kingdom, and despite calls for increasing research in to male survivors' experiences, the sexual abuse of males is frequently denied, misunderstood and trivialised (Spiegel, 2003). Qualitative studies exploring CSA are becoming more prominent in the existing literature, however those using male samples are still largely underrepresented. Research investigating this bias highlights that males are less likely to disclose CSA than females (Alaggia, 2004; Hunter, 2011; Sorsoli, Kia-Keating & Grossman, 2008) and therefore may be unlikely to participate in research. Seeking to estimate the prevalence of CSA amongst men, Holmes and Slap (1998) found that such rates vary widely, ranging from 4% to 76% depending on the study cited. Methodological issues, might perhaps account for the diversity in statistics presented in the existing literature, nevertheless, it is widely cited that men are reluctant to report or disclose CSA or to seek help for associated problems (Alaggia, 2004).

Several societal norms may contribute to this underreporting, including the expectation that boys should be dominant and self-reliant, the notion that early sexual experiences are a normal part of boys' lives, fears associated with homosexuality and pressure on males not to express helplessness or vulnerability (Nasjleti, 1980; Romano & De Luca, 2001). For many male survivors, seeking help is unimaginable and 'the consequences of disclosure are perceived as worse than the consequences of non-disclosure' (Holmes, Offen & Waller, 1997, p. 77). Furthermore, there is evidence to suggest that men struggle to find the support they need when disclosing CSA (Sorsoli et al., 2008).

The Child Sexual Abuse Accommodation Syndrome (CSAAAS) proposed by Summit (1983) described typical reactions of children who are sexually abused, and provides an explanation for why many children (and adults) do not disclose sexual abuse. The syndrome is composed

of five categories, two of which define basic childhood vulnerability, and three of which are sequentially contingent on sexual assault: (1) secrecy; (2) helplessness; (3) entrapment and accommodation; (4) delayed, unconvincing disclosure; and (5) retraction. For a further description of these the work of Summit (1983) can be referred to.

Sorsoli et al. (2008) provides valuable insight into the ways in which gender affects victim disclosure. For men, disclosing abuse perpetrated by a man is extremely difficult and shameful, raising questions about their sexuality and concerns about homophobic attitudes from others (Gill & Tutty, 1997). How boys are socialised (especially regarding sexual behaviour) is also thought to contribute to delayed disclosure (i.e. longer than one month) in male survivors (Sable, Danis, Mauzy & Gallagher, 2006). Alaggia and Millington (2008) highlight disclosure for men as being 'challenging venture in the face of socialized gender roles that promote images of men as immune to victimization or as inadequate when victimized' (p. 272), proposing that patriarchy is just as harmful for men as it is for women. Etherington (1995) identified a range of problems amongst men who have been sexually abused, including difficulties in reporting their abuse due to fear of judgement, shame and guilt. Offering support for these findings, Dhaliwal et al. (1996), Putnam (2003) and Tang et al. (2008) found that there is a sense of stigma and shame attached to CSA. As pervasive as CSA is, many survivors grow to learn that their experiences are best kept a secret (Anderson, Martin, Mullen, Romans & Herbison, 1993; McNulty & Wardle, 1994; Ullman, 2003).

Myths that surround male CSA and the notion of being sexually abused by either a male or female have been found to contribute to additional problems for the male survivor (Denov, 2003). One example is that a 'real man' cannot be sexually abused, resulting in a dilemma: report the abuse and risk being stigmatised, or keep quiet (McMullen, 1990; Yarrow & Churchill, 2009). This is explained further by Goodwin (2005, cited in Lemelin, 2006) as part of the typical male socialisation process, which requires men to aspire to certain standards of masculinity. Such standards are imposed by society, reinforced by peers, family and the community and also by men themselves. The conflict of striving to meet this masculine idea and the disparity of the real lives of males creates a "gender role strain", which can lead to a myriad of issues for boys and men. Furthermore, clinicians have proposed that male socialisation can force men to deny or minimise experiences of abuse as well as their subsequent suffering, thus exacerbating symptoms and impacting recovery (Lisak, 1994; 2005). Ouellete (2009) suggests that the phenomenon of male abuse is incompatible with

current dominant discourses associated with masculinity and, as such, proposes that this stereotype is so ingrained in our culture that it not only affects society, but also professionals and even male survivors of sexual abuse themselves. In addition, Lew and Hoffman (2000) further state that this discourse has no room for men as victims. Gender role socialisation has a clear impact on both the physical and mental help-seeking behaviour of men (Mansfield, Addis & Mahalik, 2003). When a boy is taught the masculine ideology that 'real' men do not show emotion and do not ask for help, it influences his view of help-seeking. When he then encounters health issues later in life, he may be less likely to admit his problems or seek help for them (Mansfield et al., 2003). Furthermore, Robertson (2003) associates gender-role socialisation with the fact that men are less likely to seek therapeutic interventions such as psychotherapy than women. In a study exploring preferences for support amongst men who avoid counselling, men with highly masculine attitudes reported a preference for alternative helping formats over traditional ones. The author proposes that by offering alternative interventions such as workshops, or counselling interventions that are more congruent with male socialisation, more men might be willing to engage.

Much of the disclosure literature has focused on whether or not disclosing abuse is beneficial, with studies yielding mixed results (Ullman, 2003). Disclosure response factors have been examined from the perspective of the victim, with findings emphasising that the most helpful reactions to a disclosure were responses such as being believed and offered support, whilst the least helpful responses were being blamed, treated differently, controlled, or encouraged to keep the abuse a secret (Ullman, 2000). One important conclusion from this literature is that it is not necessarily the act of telling, but rather how others respond that can be healing in some cases and hurtful in others (Harvey, Orbuch, Chwalisz & Garwood, 1991; McNulty & Wardle, 1994; Ullman & Filipas, 2005). O'Leary et al. (2010) found that participants who had discussed the abuse (rather than just told someone about it) experienced fewer mental health symptoms. Thus, it seems that the first disclosure experience has significant implications for successful outcomes in seeking help. Studies comparing child and adult disclosures of CSA have found that survivors have rated disclosures occurring in adulthood as being met with more positive social reactions and as being more helpful than disclosures that occurred in childhood (Lamb & Edgar-Smith, 1994; Roesler, 1994); however, such studies have relied on retrospective reporting from victims to draw conclusions about how others might respond.

Allnock (2010) argues that, in many cases, disclosure is vital to early intervention, yet although disclosing CSA can lead to relief and social support; it may also lead to further distress (McNulty & Wardle, 1994). Consequently, researchers have concluded that disclosure, rather than always being beneficial, is an evolving and complex phenomenon (Ullman, 2003; Ullman, Foyes & Tang, 2010). Evidence indicates the importance of disclosure characteristics in predicting the long-term effects of CSA in adulthood in samples of women (Jonzon & Lindblad, 2005); however, whether such findings can be generalised to males is unknown. It would therefore be useful to understand how men have disclosed CSA. Examining potential obstacles to disclosure would enable us to see where any barriers could be removed, perhaps increasing the likelihood for intervention during childhood.

CSA often leaves no physical signs and is actively hidden by perpetrators. Increasing importance is placed on the victims' disclosure of abuse for investigative and treatment purposes (Allnock, 2010; Finkelhor, 1994). Acknowledging and disclosing the memories, thoughts and feelings associated with abuse and trauma have long been viewed by clinicians as important aspects of healing (e.g. Harvey, Orbuch, Chwalisz & Garwood 1991), and in many cases, disclosure is vital to early intervention (Allnock, 2010). Whilst the availability of services and resources for female survivors has helped to reduce the stigma of being sexually abused and assisted women to come forward and access help, this has not been the case in the male population, according to Mendel (1995). Therefore, research investigating the barriers to help-seeking and engaging in therapeutic interventions is needed.

The current study sought to add to the existing literature, adopting a phenomenological approach to capture the experiences of help-seeking in male survivors of CSA. According to Berg (as cited in Mudaly & Goddard, 2006), qualitative research allows participants to '...tell their own stories in their own voices' (p. 66). Furthermore, Etherington (2000) documents the therapeutic significance of telling one's story; therefore, it was considered that a method to facilitate this would provide rich data from survivors themselves. As such, Interpretative Phenomenological Analysis (IPA) was considered for use because it aims to give voice to, and examine in detail, the lived experience of participants, and how they make sense of these experiences (Smith, 2004). This is particularly important considering the sample: male survivors of CSA, a group who have been considered as neglected in the existing literature (Chouliara, Karatzias, Scott-Brien, Macdonald & MacArthur, 2012; Dube et al., 2005; Mendel, 1995). Increasing numbers of studies have documented the utility of IPA in exploring under-

researched areas (Smith 2004). Furthermore, the efficacy of an IPA approach has been illustrated with both males and females in a study by Phainchat and Townsend (2011) and in a case study with a male participant exploring the links between masculinity and men's health behaviour (de Visser & Smith, 2006).

This paper presents the findings from a larger project which explored experiences of help-seeking in male survivors of childhood sexual abuse. This paper's focus is the emergent themes which revealed the experiences of the disclosure process and subsequent help-seeking as a male survivor of CSA.

## **2. Methodology**

### ***2.1. Participants and Procedure***

The study was advertised via flyers handed out at a conference on the topic of sexual abuse, via social networking groups on Facebook and links placed on websites supporting survivors of CSA. Those who enquired about taking part were provided with an information leaflet giving full details of the study. Seven male survivors of CSA were recruited following their expression of interest and willingness to participate in the research project. Prior to taking part in the research, those interested were informed of the purpose of the study and gave their written consent. Face-to-face semi-structured interviews were carried out, enabling an in-depth exploration of the participants' experiences of help-seeking. Two interviews were conducted using Skype. To minimise intrusion for the participants, minimal demographic details were collected. All participants were male, over the age of 18 and considered themselves to have been sexually abused during their childhood (before the age of 16). Interviews lasted between 60 and 90 minutes, were audio-recorded and later transcribed.

### ***2.2. Ethical Considerations***

This study was conducted as part of the requirement for a Professional Doctorate in Counselling Psychology, in accordance with the ethical procedures of the British Psychological Society (BPS, 2009). Ethical approval was also obtained from City University. Participants gave informed consent and were made aware that they could withdraw from the study at any stage up to a month before publication. All data were stored securely and names and identifiable information have been changed to ensure confidentiality.

### **2.3. Analysis**

Each transcript was analysed separately using IPA, as described in Smith, Flowers and Larkin (2009) and was guided by two aims: 1) to understand and represent the experiences of the participants as closely as possible; and 2) to interpret this understanding within the wider context of a particular situation (Larkin, Watts & Clifton, 2006). Transcripts were read and re-read and conceptual themes were created which captured the essence of each participant's account. Emergent themes were listed with connected themes forming clusters of sub-themes. The iterative process was continued throughout analysis to ensure that the data has been appropriately represented.

### **3. Results**

Analysis of all seven transcripts identified four master themes: 'Disclosure', 'Searching', 'The Help-Seeking Journey' and 'Making Sense and Moving Forwards'. The theme 'Disclosure' is the focus of the results presented here, chosen to illustrate the complexities men face in disclosing CSA. The importance of disclosure in the healing process seemed paramount and has significant implications for current service protocols. The additional themes and discussion can be found in the text of the original research project.

#### **3.1. Disclosure**

During analysis of the transcripts, the experience of disclosing CSA was one of the key themes that emerged from participants' accounts, revealing their unique experiences pre-, during and post-disclosure.

'Disclosure' is split into four sub-themes: 'Pre-Disclosure Dissociation, Detaching and Distancing', 'Secrets and Silence', 'The Process of Telling' and 'The Freedom of Disclosure'. These sub-themes together examine the experiences of participants prior to disclosing CSA, explore the context in which participants attempt to make first disclosures, and share the in-depth reflections of participants recalling what it was like for them post-disclosure. At the time of the interview, all participants had disclosed childhood sexual abuse in one context or another, either by speaking out, or by sharing written material with family. The focus on this theme expands upon the act of simply telling another person about what happened to them as a child, and illustrates the intricate processes involved in the disclosure process for the participants who took part in this study.

### **3.1.1 Pre-disclosure ‘Dissociation, Distancing and Detaching’**

Participants began by describing their journeys towards the process of disclosing. Implicit amongst the narratives was a need to remain silent. A number of participants described aspects of their behaviour that could be considered as dissociation. Others used the term to describe how they cut off from their experiences. Dissociation refers to the psychological defence mechanism of separating oneself from the traumatic memories; similarly, detaching refers to cutting off from the past, either denying a past existence or just ‘forgetting’ about what happened. Participants shared the theme of distancing themselves from others, including friends and family members, perhaps as a form of protection against the potential of further abuse, or as a means to prevent others from finding out what had happened to them. Joe provides a description below of how it was possible for him to distance himself from others and create a new identity by changing his name when he joined the army:

*I seem to remember this is a new start; I was escaping all of that into a normal world, so I called myself Mark Bradley. [...] So I was exploring who I was really... like, so yeah, so I think... then I told myself it didn't... it happened, but it didn't matter, that cliché. All these clichés are usually true, so yeah, and that's what I sort of said to myself, "it doesn't matter", and I was sort of like "you're a big lad now get on with it", you know I was a soldier. (Joe, P14, L13-19)*

By embracing an opportunity to change his name, Joe explored being someone different; creating a facade that concealed the secrets of his past. Perhaps this enabled the temporary escape in to a so-called ‘normal’ world. His choice of career is also noteworthy. Joe became a soldier, perhaps to enhance his masculinity: as he explains ‘You know, I was a soldier’, almost as if suggesting that he should be able to cope with his past or as he puts it, ‘get on with it’ (his life).

Ben and Joe engaged in a variety of coping strategies in an attempt to escape their pasts, and both shared the experience of keeping people at a distance:

*I got into the drugs and that lot, and used to use to very much keep people distant apart from... drinking buds. That was it. And I've always been a person, I'll be... best friends with somebody, talk to them every day, see them*



*every day, then one day I'll stop getting in contact. You're gone. (Ben, P7, L1-4)*

*I would do something to stop that closeness, you know, so I would distance myself or build people up into pinnacles and knock them off and all that type of stuff, you know, all that went on... erm because you couldn't stay, because you'd be discovered. You'd be found out, they would see the real you, and all that stuff is real. And so I'd do a runner. (Joe, P23, L25-26 & P24, L1-4)*

These excerpts reveal how both participants closed in the walls around them and kept people from getting close to them. For Ben, drugs and alcohol were used, perhaps as a means to block out the traumatic experiences he had suffered. By cutting off from others Ben was able to distance himself from anyone that could potentially harm him. Being alone appeared to be a strategy he devised to keep himself safe, possibly with the intention of preventing him from experiencing any further emotional pain. Joe, on the other hand, went in to the Army and detached completely from his previous life, creating a new identity along with his new career. His remark about building 'people up in to pinnacles' and then knocking them off suggests he might have intentionally sabotaged relationships with others to keep them from getting close to him. The fear of being found out and the real Joe being 'discovered' is evident, resulting in him running away from both his past and present life; this illustrated the notion of secrecy and the need to keep his past hidden. Joe considered his behaviour as common amongst survivors of CSA:

*I'm almost a classic cliché of the survivor male or female, who goes through childhood, um then goes into adulthood and survives and adapts, almost dissociation... is a rather strong word isn't it, but puts it away and erm gets on with life. (Joe, P1, L15-17)*

By associating himself with the 'typical survivor', Joe is able to justify his behaviour as a normal response to his situation. Looking back on his life he implies that he, himself, was able to survive, adapt and put his experience away in a box, then 'got on with life'. In contrast to this perspective, other participants described the need to use various methods to cope with the repercussions associated with CSA, before they began help-seeking, as Dan illustrates:

*I mean that it's you know, destroying you, you know, a lot of that... and being happy to live in a gutter as a kind of coping mechanism, it was a coping mechanism, a kind of loss of identity, and it was a coping mechanism....I mean along with the heroin obviously. (Dan, P4, L17-20)*

In contrast to Joe who created a new life, Dan's comment 'destroying himself' implies engaging in a form of self-sabotage, and it could be considered that, for a time, he perhaps gave up on life. In contrast to these experiences, one participant mentioned that he was able to 'forget' what had happened to him:

*I just forgot it for a long time. (Barry, P6, L18-19)*

The act of 'forgetting' could be considered as similar to denying it happened, and for Barry, if he 'forgot about it' it is possible that he was able to focus on other aspects of his life. By removing the experience from his mind, he could free himself from the emotional suffering. However, for other participants, it was evident that forgetting was not an option, as Joe clearly describes:

*I remember she's (Esther Rantzen) speaking about it, and watching her, like, not disassociation... it's someone else. Sort of like, you know it's someone else... that was another life, that expression. It really was like that with her. So I knew it was connected to it... you wouldn't have known by my... you wouldn't have known because you just don't show. Because that was never gonna show... in fact my wife didn't know till 2000 and I got married in 81. (Joe, P15, L5-10)*

Joe reveals how, despite cutting off from his past life, a sense of it always remained in the background, suggesting that perhaps his memories did not fully disappear from his consciousness and that he could never escape from them entirely. As the past intrudes on the present, prompted by the subtle triggers from watching a television programme, Joe is forced to face the reality of his past. The latter part of his comment illustrates the notion of secrecy, and his determination ('because that was never gonna show') to keep his experience of sexual abuse hidden from everyone, including his wife.

This sub-theme captures the essence of participants remaining silent to escape from their traumatic pasts. Using a variety of methods, participants denied, detached or dissociated from the memories of their abuse, and tried to get on with their lives. Here, the idea of survival living is apparent. This refers to the notion of just getting by in whatever way possible, in the face of coping with any psychological repercussions from the past. For some, this worked for many years. By denying or detaching from their experiences and emotions, or creating new identities, participants were able to hide or suppress the experience of CSA prior to their first disclosure.

### **3.1.2 Secrets and Silence**

The second sub-theme 'Secrets and Silence' captures participants' reluctance to speak out about their experiences of CSA and reveals the implicit need to remain silent. Secrets and silence was further separated into two themes: 'delaying disclosure and keeping "it" quiet', and 'something triggering or enabling' disclosure. Participants who delayed disclosure reported doing so both consciously and unconsciously. This was associated with a number of factors, including fear (of speaking out), protecting themselves and others, and not being able to share with or trust anyone. 'Something triggering or enabling disclosure' illustrated how at a certain point in the participants' lives, something triggered or enabled them to disclose their experiences.

#### *Delaying disclosure and keeping 'it' quiet*

Participants made a number of references to the need to remain silent about their abuse in childhood. An example is illustrated by Dave, whose strict religious upbringing contributed to his inability to disclose that he had been sexually abused by a close male relative:

*I never felt... I never felt safe around anybody in a sense in terms of, I never felt I could really talk and open up to anybody and that's a tragedy for a child... so I kept, I kept the memories, I kept the experiences all buried until I was, yeah until I was thirty eight. (Dave, P4, L6-7 & 11-12)*

Dave's excerpt captures two themes shared by all of the participants: 'the reluctance' to speaking out and the length of time it took to speak out (delayed disclosure). Dave illustrates his vulnerability with his statement 'I never felt safe'; this could have been due to the fact that his perpetrator was a close male relative, or due to his strict religious upbringing. Both of

these together perhaps left Dave feeling powerless. As is revealed later in the interview, Dave's family were unsupportive following his disclosure, preferring that he did not discuss such things with them. With this in mind, it could be considered that Dave's remark 'that's a tragedy for a child, not having anyone to talk to' is indirectly illustrative of his own feelings about his childhood. Like Dave, several of the other participants recounted similar experiences when asked if they had been able to disclose to their parents:

*Researcher: "And you never told?"*

*Jack: "No no, no no no, that would have been the kiss of death." (Jack, P12, L1-2)*

Referring to the idea of speaking out, Jack implies that would be the end for him, 'the kiss of death'. Perhaps he is referring to the potential end to his relationship with his parents if he had told them about being abused. His powerful words highlight that it was never an option for him to speak out. Similarly, Sam eloquently captured the fear surrounding the thought of speaking out, when talking about his reasons for delaying disclosure:

*When it happened I was afraid to say anything erm. I guess you know more about it than I do because I can only speak from my experiences but as a child... you feeling one thing but if you say something you know the consequences of what it's gonna do to the rest of the family is gonna be even worse and that's your fault. So I kept quiet. (Sam, P2, L19-22)*

Sam highlighted a sense of confusion when faced with the difficult dilemma: speaking out versus keeping quiet. His fear of reprisal is evident, and even as a child he was aware of the potential consequences of disclosure, and not wanting to be blamed for what had happened to him. Other participants shared this theme of needing to maintain the silence surrounding CSA for various reasons:

*At the time I remember thinking "gosh I should do something" but I was just too afraid to do so... there was a real stigma attached to talking about this... (Jack, P4, L11-12)*

*The actual erm, silence it just think that erodes the human spirit. (Joe, P25, L25)*

Both Jack and Joe revealed their thoughts about the notion of silence surrounding CSA. Jack recalled the conflict between wanting to speak out, but being unable to due to the fear and stigma of doing so. Joe's use of the powerful phrase 'erodes the human spirit' concluded that the 'silence' is damaging, not only physically and psychologically, but on a deeper level, as if eroding the soul.

Several participants described instances of being asked directly as children about whether they were being sexually abused. They recounted denying the abuse at the time, even though they were conscious of what had happened to them, as described by Dan, who was abused by a stranger, then again later by teachers and pupils at his boarding school:

*I was asked once by that new head teacher if anything odd had happened and I hadn't been able to trust them enough to say anything. (Dan, P2, L16-18)*

Dan illustrates his complete lack of trust in others, which is understandable when considering that he experienced abuse by an adult as a young child, then again was abused by adults in a trusted position in his early teens. The impact of this shattered Dan's ability to trust in anyone and, consequently, he delayed disclosing CSA until in to his adulthood. The theme of delaying disclosure was apparent for all of the participants, with the length of time participants waited varying from 15 years to over 30 years. Several participants described making attempts at disclosing in childhood; however, these were either dismissed or ignored, and it was reported that as a result of this, they then delayed further disclosures for many years. This is noticeably summarised by Ben:

*The next time I kind of tried to do anything about it was when I actually went to rehab to sort out the problems... which would be October 1999 so at that point I'd have been what 29 years old and it all gone on about fifteen years... (Ben, P1, L15-17)*

Ben's description of his unsuccessful attempt to disclose and the length of time until his next opportunity illustrated his clear and vivid memory of this experience; he includes specific

dates, as if the encounter is firmly etched in his mind. Likewise, Joe shared a similar experience to Ben, of trying to disclose and the negative response he received:

*I think it tried to see what the outcome would be in 94 if you said it. What would happen... and what I got was, 'well don't tell me anything bad'. You know and you think 'well, where would you go, where... you don't want to go and tell somebody about all that stuff if all they are gonna see is bad... well you might be bad because you don't know, do you... if you are bad?...' because you get sort of like confused in your head about it really, you know.*  
(Joe, P15, L20-26)

His words 'I tried to see what the outcome would be like' suggest that he was perhaps experimenting with a disclosure to see what the outcome might be. The therapists' response 'don't tell me anything bad' left him questioning himself and his role in the abuse, potentially reinforcing the confusion that he experienced when the abuse occurred.

The above excerpts demonstrate participants' experiences prior to disclosing CSA. All perceived the need to remain silent, thus keeping their abuse a secret for many years. Along with the experience of CSA comes an implicit sense of fear about speaking out, perhaps instilled by the perpetrator, or simply due to the stigma and shame of knowing that something like this had happened to them. Participants' confusion was evident, as is shown in the excerpt by Joe, who describes questioning himself: 'Was I bad'? This was a question which crossed the minds of several of the others who struggled to make sense of what had happened to them. Ultimately, they knew that such things should not be talked about, and buried or suppressed their traumatic memories until something triggered or enabled disclosure, as is described in the sub-theme below.

#### *Something triggering or enabling disclosure*

Embedded within participants' narratives was the triggering of a disclosure at a particular time in their lives. Dave's experience of this is highlighted below:

*It was just something that I suppressed, and until there was a significant moment in my life, at that age when I had a bereavement, at which point... all the memories became extremely vivid and extremely painful, and powerful,*

*and then... that's why I started the long road of trying to find help. (Dave, P1, L12-15)*

Dave's CSA experience was described as initially something he could 'suppress' until a certain point in his life. It appears that his father's death triggered an emotional response, which led to a descent into the memories of his past, leading to the realisation of the need for help, and as Dave describes, the beginning of a 'long road' ahead of trying to find appropriate support. The death of a family member also led Dan to open up and speak out about his experiences:

*I suppose after he'd died I felt I was more free to talk about it. (Dan, P11, L20)*

Following his father's death, Dan states he felt free to open up and talk about being sexually abused. It is possible that Dan might have refrained from telling his parents, either to protect them from hearing what happened to him, or due to the fear of what his father might have thought or done.

Although participants illustrated their ability to suppress their abuse experiences, it soon became apparent that this was only temporary. Participants shared the intense moments at which their pasts exploded into their present lives, as is eloquently illustrated by Joe:

*She (referring to his wife) didn't know anything about the sexual abuse till 2000, when, you know there was no barriers to defend yourself against the reality of that other life. Cos it exploded into this life. You know it had been suppressed and buried for so long. (Joe, P15, L15-18)*

Illustrating the lengths he had gone to in order to keep his abuse a secret, Joe claims that even his wife was unaware. His words imply that his barriers came down; all his efforts could not protect him from the reality of his past life, which he powerfully describes as 'exploding' into his current life. The use of the term 'exploding' infers an overwhelming and intense experience, out of Joe's control. Dave reported a similar experience, as he revealed how he came to realise his need for help:

*From the moment I realised the enormity of what had been done to me I felt I needed some sort of help, but I didn't know what... (Dave, P16, L12-14)*

It appears as if all became clear, the 'enormity' and extent of his suffering was realised and, as such, prompted Dave to begin the search for help. His confusion is evident: 'I didn't know what'... but he knew it was time to seek help.

For several of the participants, disclosures occurred unexpectedly, prompted by either a person or being in a particular environment. This theme is captured Joe:

*I went to see this doctor and I remember saying to him, saying, 'I've got this real bad kidney problem', which I had, I had a real bad pain in my kidney, so he said "okay we'll do some tests", and I said "but also I've been abused in childhood...sexually and I would like some specialist help please. I'd like to see a specialist counsellor for sexual abuse". (Joe, P3, L19-22)*

Joe stated how he went to the doctor for a particular reason but ended up disclosing that he had been sexually abused. One could speculate that Joe planned his disclosure, with the aim of starting with one problem to break the ice, before moving on to disclosing CSA. Alternatively, Joe perhaps unconsciously blurted out the fact that he had been abused whilst in the safe environment of the doctor's surgery. Ben also found that being in a particular environment enabled him to open up about his past:

*Its more for the fact that I sort of went to the clinic... after I went to the clinic the stuff started coming out. (Ben, P2, L47-49)*

In response to the question 'were you ever able to speak out?' Ben states that it was not an option for him until going in to a rehabilitation clinic. His words 'the stuff started coming out' implied a lack of control over what was happening. Perhaps the safety of the environment, and possibly the reduction in his substance use, facilitated the act of disclosure in a way that he had not anticipated.

In addition to personal experiences such as bereavements, or the environment enabling disclosure, another reason discussed was shared by Sam, who wanted to reveal his story to his family to justify his behaviour as a child:



*I decided it was about time they all knew why I behaved the way I did. (Sam, P1, L15-16)*

During the interview, Sam shared a sense of feeling vulnerable about disclosing CSA, and having previously only disclosed to close family, speaking to me was his first experience of a disclosure face to face (over Skype). Similar to other participants, Sam reached a point in his life where he felt that he was able to speak out; however, his reasons for doing so were notably different from those of other participants. Sam had been taken in to care as a child due to his behaviour and had ended up in prison for several years in his early adulthood. He felt that others' perception of him was as inherently bad; therefore, by writing about his experience of CSA, he was able to justify why he had acted in the way that he did. Finding a way to speak out indirectly helped Sam to share his story with his family.

### **3.1.3 Experiences of Telling**

In the re-telling of their stories to me, participants illustrated the facets of disclosing CSA. As they recalled these experiences in-depth, vivid and evidently traumatic memories were shared. Participants appeared keen to describe experiences of first and subsequent disclosures, as if telling a story of the journey of the help-seeking process.

Vivid and detailed recollections of disclosure experiences were shared, highlighting the intensity of the memories for the participants. This process is eloquently described by Joe:

*And it, like all survivors the first opportunity you have to speak you think, to supposedly an expert, you know it all floods out, you use a form of verbal expulsion you know it's like sick, you know, letting it all out, so she just got it, bang bang bang. (Joe, P4, L20-23)*

There are two interesting points that Joe highlights here. First, the evident lack of control he insinuates that is associated with the act of disclosure, demonstrated by his words 'verbal expulsion'. His words suggest that the disclosure came out frenziedly, and the use of 'bang, bang, bang' imply the therapist was shot with all of this emotion pouring out of him. Secondly, Joe reveals his scepticism about the therapist, who he describes as 'supposedly an expert', illustrating perhaps his expectations of the therapist as being knowledgeable and able to contain his disclosure.

In the previous sub-theme, participants reported how disclosures often occurred unintentionally or as a response to another situation. This theme is further expanded on below, as Joe explains his 'experience of telling':

*I said "Well you know, I have also lots of other baggage like erm being abused, and I dealt with it" and I can remember it what she said, she said er "well if you want to talk about that, erm well I don't want to hear anything bad..." and I sort of like looked at her and thought "I'm not sure what would be bad", but I then shut up, and didn't say anything, so the last five minutes of my session was silent, and I left. (Joe, P2, L15-20)*

Joe's unexpected disclosure appeared to change the dynamics of the therapy session. His statement 'I have lots of other baggage' and 'I dealt with it' was possibly a way of trying to prove a point to his therapist, that he has been through worse and got through it; however, his experience was that the therapist did not want to hear the 'bad stuff'. Her response appeared to shock him and led him to question what she meant by 'I don't want to hear anything bad'. He later inferred from this that she thought he might have gone on to abuse others. Like Joe, other participants also provided intricate accounts of their disclosure experiences:

*I went and saw this guy erm... who and again I can still remember his name, who proceeded to tell me first of all basically how great he was... [...] basically he didn't wanna know and his kids had been to the school that I'd been to where I was telling him about my abuse and his response was "my kids had a great time...." I could of punched him. I was just dumbstruck; I didn't respond. I just left feeling like shit as usual you know... (Dave, P18, L15-24)*

Dave's experience of telling a therapist about his abuse was evidently a negative one. Dave's own agenda, his disclosure of abuse, was trivialised by the therapist's inferred lack of interest and inappropriate comment about his own children having 'a great time' at the same school in which Dave had been a victim. His anger is clearly expressed by his statement "I could of punched him". At a time when Dave needed undivided attention from the therapist, he was angry to find the therapist was not focused on him but on revealing personal information

about his own family. Dave also highlights his annoyance with the therapist's attitude of sharing his qualifications, which was perhaps perceived by Dave as showing off, or triggered reminders of a power imbalance that Dave might have associated with his abuser. He described leaving the session angry and disappointed and 'feeling like shit again', let down by another person who he had expected might be able to help him. Joe provides an excellent summary which powerfully illustrates this theme further:

*I think, what people don't realise when you're expelling that, it's like expelling parts of you, you know because you hold it in so long, it's in your psyche, your consciousness, so actually exposing it to fresh air, its fresh it's like a puss coming out a bad wound. You know all those thoughts, so yeah and I was just shocked at the process. So I went away and you're not thinking rational so your mind is so focussed on 'are you mad really?' (Joe, P5, L1-5)*

Joe clearly captures the sense of vulnerability, echoed by participants when disclosing CSA. He highlights 'others' lack of understanding about the intensity of this process, using the words 'expelling' and 'exposing it to fresh air'. His strong and vivid descriptions 'it all floods out' and 'puss coming out a bad wound' could be associated with the release of poison. Leaving the session highly anxious, Joe reflected on his own sanity and as if he was the one with the problem, again highlighting possible feelings of blame. His narrative emphasises the emotional pain of expelling his memories that he had held in so long.

Other participants were less lucid in their descriptions, and shared brief details of their experiences of telling:

*And so I just... initially I just put it all, because I like to write... because I, I'm more confident in writing than I am in talking with somebody face to face. I can say things that I want to say better on paper, so I did it basically for meself. (Sam, P1, L16-18)*

Instead of a verbal disclosure, Sam reveals how he wrote about his experiences. He emphasises his lack of confidence in speaking out, preferring instead to put pen to paper, enabling him to articulate himself. This is perhaps also a reason for the lack of detail shared during our interviews.

Feeling let down appeared to be a common theme amongst the participants; Ben captures the essence of this, sharing his mother's response after Ben had asked her if she wanted to know what had gone on between Ben and his brother Barry:

*The next day my mum came back and went "well I've thought about what you said and actually I'd rather not know anything". Ok, so they happily live in this little puddle of denial... (Ben, P3, L26-28)*

Ben had been sexually abused by Barry and by Barry's girlfriend for several years. The impact of his parent's decision, that they would rather not know, highlighted to Ben that they would not be able to offer him the support he needed. He disguised his sadness with his comment about them 'living in denial', but one would imagine that it must have been extremely painful for him to build up the courage to disclose to someone he cared about, and then have them tell you they do not want to know. Dave and Dan described similar experiences:

*My family basically united against me... not in denying that it happened but simply why did I have to bring it up after all these years (laughs) and why did I have to bring it up around dad's death and I don't think they ever had a clue as to the impact of abuse that I, I, think they probably still don't have a clue about the real impact of it. (Dave, P2, L2-5)*

*He said "don't tell anybody" and of course I ran home in floods of tears and told my mum all about it. And she said "try and forget about it." (Dan, P1, L23-24)*

Dave's laughter following the comment 'why did I have to bring it up after all these years' was suggestive of his utter disbelief at their response, and it is evident that he felt his family could not comprehend the detrimental impact of what had happened to him and the psychological repercussions he continues to experience as an adult. Although, as he states, his family did not deny the abuse had occurred, the very fact that they considered it to be almost an inconvenience to bring it up years later implies they felt that it was not important, invalidating his feelings and suffering and further reinforcing the commonly held view amongst participants that 'I should have got over this by now'. Similarly, Dan's distress was

also trivialised by his mother, who told him to 'try and forget about it'. For a child who had just been raped and was clearly in distress, hearing this would potentially have contributed to further confusion and anguish. The silence instilled by the perpetrators 'don't tell' was then reinforced again by his mother.

Later in the interview, Dan describes how he went from remaining silent to the opposite:

*I went through that phase of just blurting it out to everybody as I mentioned, but some people you know, I lost a lot of friends I think because some people just can't handle it if you're too splurgy about it. (Dan, P10, L19-21)*

Here Dan infers that he wanted everyone to know what happened to him. He perhaps later realised that others might have been uncomfortable with his frequent discussion about his experiences of abuse. Other participants shared a similar perception of finding others unsupportive of their disclosures:

*The individuals I confided in minimised it and kind of said "Jack he did nothing, what's your big deal". That I found deeply unhelpful and just made me think... "God I'm making a big deal out of this?" (Jack, P24, L12-14)*

Jack demonstrates that the responses of others can be particularly unhelpful, especially when they minimise or are dismissive of what went on, and can potentially impact one's perceptions of themselves and their role in the abuse, illustrated by Jack's words 'god I'm making a big deal out of this?'

Not only were family and friends found to be unsupportive, but those in trusted positions outside of the family were also experienced as unhelpful. In particular, several participants considered that the group therapy setting would be an optimal environment to share their disclosures with others; however, instead, they experienced the group as unpredictable and lacking in support. Ben shares an example of this below as he shares his response to the therapist's question about why he had come to the group:

*"Ok yeah... from the age of eight I was abused by me brother", bla bla bla bla, and the room went absolutely deadily silent, and people waited about*

*thirty, forty seconds, and then someone changed the subject, and so he (the therapist) started asking them about the new subject they brought up, and I thought, "ok, probably something about their fucking dog." (Ben, P9, L28-32)*

Ben relays his experience of being abused by his brother, sharing what one might assume is a deeply painful experience to a group, his use of 'bla bla bla bla' could be illustrative of him attempting to minimise this experience. His use of sarcasm when describing this experience is perhaps used to deflect from this difficult experience and possibly another occasion, which contributed to him putting the barriers up and reinforcing his lack of trust in others. Such experiences were commonly reported across the participants' accounts.

#### **3.1.4 The Freedom of Disclosure**

Despite the difficulties surrounding the process of disclosure, all of the participants found that after they had divulged their experiences in whatever form, they felt a sense of relief or freedom. This is illustrated by Dave:

*Researcher: "How did you get that determination to change things?"*

*Dave: "Well it was the disclosure that freed me up" (Dave, P22, L5 & 7)*

In a similar way, Sam described his disclosure process and the freedom of finally being able to share what happened to him:

*I was always to blame you know for, everything. So I decided it was about time they all knew why I behaved the way I did. (Sam, P1, L15-16)*

Like several others, Sam perceived the act of disclosing as a way of freeing himself from others' perceptions of him as bad. Although it took him a long time to gain the courage to speak out, he shares how it felt good to eventually do so:

*It's good to get it out, you know... its erm... but it's taken a long time. Like I say, 53 years of age... well its taken nearly 45 years you know to have the balls to tell people. (Sam, P8, L22-24)*

Several participants expressed regret about not being able to speak out as a child; however, none of the participants reported regretting disclosing their experiences of sexual abuse. This is clarified by Joe:

*I've never met a man that's disclosed who regrets the disclosure. (Joe, P25, L21).*

This theme has captured the complexities of the disclosure process for the participants who took part in the study. All of the males described their first experiences of disclosure, whether this involved disclosing to family, friends, police or during therapy, reflecting on the responses and impact that disclosing CSA had on their lives. Overall, participants experienced the disclosure process as a complex one, confounded by a variety of factors and as equally distressing as it was freeing, resulting in mixed emotions amongst the participants. Nevertheless, the majority of participants reported a sense of relief and freedom after disclosing their abuse, enabling them to begin a new journey towards help-seeking.

#### **4. Discussion**

The section of analysis presented here has illustrated the complexities surrounding participants' experiences of disclosure. The following section will discuss this theme with relevance to existing literature.

##### *4.1. Engaging Men*

A key theme which brings together the findings of this study is the importance of engaging men as survivors of CSA. Whilst many survivors find it difficult to disclose CSA (Gavey, 2003), the findings from the current study illuminate a number of issues specific to male survivors. Participants shared how societal expectations contribute to the silencing of male survivors of CSA and the implicit perception of needing to keep the abuse a secret was prevalent. Also evident is the detrimental impact of negative responses to the men's disclosure experiences, and how this can potentially deter men from further attempts at seeking help.

##### *4.2. Secrets and Silence*

Prior to disclosing CSA, participants described believing that it would be in their best interests to remain silent about their experiences. Durham (2003) proposes that deciding to keep abuse a secret appears to be '...inextricably bound up with the messages the child receives

from the adult during the abuse itself' (p. 81). Indeed, a number of the participants described being told not to tell anyone about the abuse, and this contributed to the notions of shame and blame, which further reinforced the need to remain silent. Spiegel (2003) argues that the majority of sexually abused boys and men do not disclose their abuse out of fear of negative consequences. This was pertinent for Dave and Dan, who kept quiet in order to protect family members. Similar findings have been described in existing research (Alaggia, 2004; Draucker & Marsolf, 2008; O'Leary & Barber, 2008; & Ullman, 2003).

Draucker and Marsolf (2008) present a theoretical framework describing how survivors of CSA tell others about their abuse experiences. Their initial theme 'Starting the Story: The Story-Not-Yet-Told' is similar to the sub-theme in the current study of 'Pre-Disclosure - Dissociation, Detaching and Distancing' whereby participants described being aware of their experiences but were unable to speak out, and actively avoiding, denying or dissociating from their past experiences. The use of distancing as a coping strategy impinges upon the individual's use of social support and effectively leaves them isolated and vulnerable (O'Leary, 2009). Marx, Calhoun, Wilson and Meyerson (2001) argue that survivors of CSA might attempt to ameliorate the negative emotions such as shame that manifest in adolescence and persist into adulthood through the use of substance misuse and self-regulation through the spontaneous use of dissociation. In the current study, over half the participants described using similar forms of coping strategies prior to disclosing; Ben and Dan used drugs, Dave referred to himself as an alcoholic and others described dissociating to avoid painful memories of their pasts.

#### *4.3. Responses upon Disclosure*

When attempting to disclose for the first time, all participants reported experiencing insensitive and harmful responses, which included their accounts being disbelieved, minimised or dismissed. In a study examining mothers' responses to disclosure, Heriot (1996) found that 14 per cent did not believe their child and a further 12 per cent claimed that they questioned the veracity of the allegations. Similar findings were present in the current study. The assumption that children will benefit by telling someone about their abuse (Alaggia & Kirshenbaum, 2005) can therefore be criticised. Indeed, the participants in the current study described the negative and traumatic experiences of their disclosures, which, for several participants, led to many years of remaining silent. The shocking responses of some professionals involved in relation to initial disclosures and the impact this had on subsequent



disclosures, help-seeking and the ability to develop trusting relationships with others in adulthood were illustrated by Dave, Joe and Dan. Feiring, Taska and Lewis (2002) state that a disclosure that is met with a dismissive, disbelieving, unsupportive or hostile response can be traumatic and lead to long-term mental health problems, whereas recognition and confirmation of the CSA experiences positively affected the wellbeing of survivors (Denov, 2004).

As Anderson Martin, Mullen, Romans and Herbison (1993) note, survivors of CSA often disclose their abuse histories after attending therapy for other reasons, and many will not understand how an experience that happened in childhood could still affect them in adulthood. Professionals often fail to hypothesise that their male clients may have been abused and do not create the conditions that would enable males to talk about the abuse (Holmes et al., 1997). Disclosing CSA can lead to immense relief but may also lead to further distress for many survivors (McNulty & Wardle, 1994); consequently, disclosing is an event that likely bears on meaningful aspects of a survivor's recovery. Those who do seek therapy may present with a complex array of difficulties (Berliner & Elliott, 1996) or co-morbid symptoms that make planning interventions more complex and may require concurrent or sequential use of more than one therapeutic modality (e.g. substance use treatment followed by exposure therapy). Factors such as these must be understood and taken into consideration when considering interventions for survivors seeking help.

Disclosure response factors have been examined from the perspective of the survivor, with findings emphasising that the most helpful reactions to a disclosure were positive responses such as being believed and offered support, whilst the least helpful responses were being blamed, treated differently and encouraged to keep the CSA a secret (Ullman, 2003). The current study adds support to these findings. One important conclusion that may be drawn from the disclosure literature is that it is not necessarily the act of telling, but rather how others respond, that can be healing in some cases and hurtful in others (Harvey et al., 1991; McNulty & Wardle, 1994; Ullman & Filipas, 2005). O'Leary, Coohey and Easton (2010) found that participants who had discussed the abuse experienced fewer mental health symptoms. It seems, therefore, that the first disclosure experience has significant implications for successful outcomes when help-seeking.

#### 4.4. Stigma and Myths

Gonsiorek, Bera and LeTourneau (1994) describe the myths associated with male sexual abuse that may prevent disclosure. Several of these resonated with the participants' accounts, in particular:

*'If a Male Has an Erection and Ejaculates, He Consented...' 'If abused by a Male, the Abuse Occurred Because the Boy is Gay or Acted Gay...' 'If Forced or Tricked by a Female into Being Sexual, the Boy Should Consider Himself Lucky...'* (Gonsiorek et al., 1994, pp. 47-49).

These myths perpetuate notions of blame, and potentially mediate their detrimental effects in a number of ways. Specifically, they promote unfavourable responses to the disclosure of abuse, which can lead to self-blame, powerlessness and relative social isolation, as found amongst the participants' narratives in the current study. Dan described being aware of such myths and the impact of being labelled 'a paedo' after speaking out about his experience of CSA, an aspect he considered to be related specifically to being a male survivor.

Sorsoli et al (2008) provide valuable insight into the ways in which gender affects victim disclosure; for men, disclosing abuse perpetrated by a man is extremely difficult and shameful, raising questions about their masculinity and concerns about homophobic attitudes from others. Alaggia (2005) highlights the presence of unique themes in male and female survivors' disclosure narratives. For men, themes that inhibited disclosure were gender-related, including fear of being seen as homosexual and feelings of isolation due to the belief that boys are rarely victims; however, women appeared to have difficulties disclosing due to internal confusion about responsibility for the abuse and fears of being blamed. Participants in the current study described a fear of speaking out in case others thought they were homosexual. This led to them questioning their own sexuality. Others reported a fear of being around men. Alaggia and Millington (2008) highlight disclosure for men as being a 'challenging venture in the face of socialized gender roles that promote images of men as immune to victimization or as inadequate when victimized' (p. 272), proposing that patriarchy is just as harmful for men as it is for women.

#### *4.5. Disclosure and the Notion of 'Recovery'*

Draucker, Martsof and Roller et al. (2011) and Chouliara, Karatzias and Gullone (2013) propose recent frameworks for recovery for survivors of CSA which emphasise the importance of disclosure for subsequent recovery from CSA. As found in the current study, disclosure mediated help-seeking. Participants revealed that their disclosures in therapy were not always responded to therapeutically, which has implications for the practice of health professionals who may encounter male survivors in their work. Unfortunately, by the time a survivor feels ready for disclosure, they may have experienced a number of unsupportive or harmful experiences, as the findings from this study have illustrated. As such, it is important for health professionals to be aware of the impact of previous negative experiences and how these might impact on the engagement and development of trust in a therapeutic setting. Professionals should be alert for signs that men may have suffered abuse in their childhood. For those providing therapy, these findings make clear that men might seek help indirectly through seeking help for other reasons (relationship difficulties, substance misuse) and, as such, it may take time for a male client to open up and disclose a history of CSA. Furthermore, it seems likely that the issue of CSA may need to be raised more than once, as several participants had been asked and did not initially disclose.

Several participants described their GPs as lacking in specialist knowledge of male CSA. Awareness of CSA and complex trauma have been identified by survivors as core requirements for a positive and constructive therapy experience (Chouliara et al., 2012). In support of these findings, the current study emphasises the need for health professionals to be educated about CSA so that they are able to respond optimally to disclosures. Psychologists should be able to respond to the different ways men present from women in therapy. Men might appear hostile or have difficulties forming therapeutic relationships. Training programmes would benefit from teaching staff about male and female CSA. Furthermore, families of survivors need educating to ensure they provide appropriate responses to disclosures, rather than minimising or disbelieving, as found in the current study. In addition, as young boys, several of the participants mentioned not being able to express their emotions for fear of repercussion. This emotional inexpressiveness can have negative consequences for men (Englar-Carlson & Stevens, 2006) and prevent them from expressing what might be considered feminine traits. This is evident from participants' narratives in the current study and was considered to impact help-seeking. Dorahi and Clearwater (2012) suggest that in seeking to better understand and address men's disclosure

and help-seeking, we are required to look beyond the stigma associated with sexual abuse itself and the 'silencing' effects of fear, confusion and shame. The media plays a role in the non-disclosure of many male CSA cases and could therefore be used as a medium to challenge the socialisation of boys and to educate parents, teachers on the subject of male CSA so that early disclosures are better responded to.

#### *4.6. Methodological and Personal Reflexivity*

The use of an IPA approach illuminates the participants' experiences of help-seeking. This approach fits well with the phenomenon being investigated, allowing for an in-depth exploration of help-seeking as described by the participants, regardless of what is known in the existing literature. The conclusions of the study are therefore a unique interaction between the researcher and the data and cannot be duplicated by another (Smith et al., 2009). Two key aspects – the double hermeneutic and the hermeneutic circle (Smith et al., 2009) – were considered throughout the analysis process. The double hermeneutic positions the researcher as attempting to make sense of participants' attempts at making sense of their own experiences. The hermeneutic circle refers to the idea that one's understanding of the text as a whole is established by reference to the individual parts and one's understanding of each individual part by reference to the whole. Therefore, each transcript was read individually and as a set of seven transcripts to reveal themes capturing the experiences of the participants.

The researcher was a Trainee Counselling Psychologist, whose interest in working with survivors of CSA arose from a placement in primary care where they encountered a number of clients whose difficulties related to CSA. It was important to maintain an awareness of the impact of this prior knowledge during data analysis to allow for the participants' narratives to emerge without assumptions or judgements.

#### *Limitations*

Researchers have described difficulty in recruiting participants from different ethnic backgrounds. Likewise, this study can be criticised for its sample of Caucasian participants. Given that cultural factors are important in defining CSA and adult psychological dysfunction (Carey & Wincze, 2001), the use of narrow samples limits our understanding of the impact CSA has on males from different ethnic groups. Nevertheless, this study provides clinicians with a perspective which can enhance their clinical practice.

## ***5. Conclusion***

In conclusion, the findings from this study have highlighted the complexities surrounding men who disclose CSA. Adopting a phenomenological approach has facilitated an insight into how men experience the disclosure process, revealing both the challenges and benefits. It is highly probable that health professionals will come into contact with clients with histories of CSA; it is therefore imperative that they are knowledgeable of this topic if advances in intervention and treatment are to be made. Health professionals can learn from the findings of this research, ensuring they are alert to the possibility of CSA and provide conditions conducive to disclosure should a client wish to bring this to therapy. Furthermore, these findings demonstrate the need for further research using male samples to reinforce and expand on the findings presented here.

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